GUY'S
HOSPITAL
GAZETTE

NEW SERIES

VOL. 85

1971

Guy's Hospital Gazette.

Guy's Hospital Gazette.

GUY'S HOSPITAL MEDICAL SCHOOL
WILLS LIBRARY

GUY'S HOSPITAL GAZETTE

VOL. LXXXV

1971

INDEX

A

Abortion Act, 333 (P)
Academic successes, 313, 373 (C)
Adams, C. W. M. A plain man's guide on how to fail Pathology, 283
Adoption: medical aspects of (D. F. Egan), 184
Adrian Stokes Memorial Fellowship, 223
Alfred Rycroft Memorial Scholarship in Dental Surgery, 652
Anaerobic respiratory cycles in man (J. S. Tilley), 445
Anatomy Department, 491, 556 (C)
Angels' Social and Sporting Club, 135
  football, 136
  rugby, 42 560
Annual Clinical Meeting: Programme, 66
Appointments
  Beckenham Hospital: House appointments, 81, 275, 437, 616
  Evelina Hospital: House appointments, 81, 275, 437
  Greenwich District Hospital: House appointments, 275, 437, 616
  Guy's Hospital: Dental H.S. 356
    House appointments, 80, 274, 436, 487, 615
  Hither Green Hospital: House appointments, 81, 275, 437, 616
  Lewisham Hospital: House appointments, 81, 275, 437, 616.
  Miller Hospital: House appointments, 81, 275, 437, 616
  New Cross Hospital: House appointments, 81, 275, 437, 616
  Orpington Hospital: House appointments, 81, 275, 438, 616
  Pembury Hospital: House appointments, 81, 275, 438, 616
  St. Helen's Hospital, Hastings: House appointments, 82, 275, 438, 616
  St. Nicholas' Hospital, Plumstead: House appointments, 82, 275, 438, 617
  St. Olave's Hospital: House appointments, 81, 275, 437, 616
Appointments vacant
  Beckenham Hospital, 22, 355
  Evelina Hospital, 21, 22, 199, 355, 535, 648
  Greenwich District Hospital, 355, 535
  Guy's Hospital: Accident and Orthopaedic Department: Locum registrar, 460
    Anaesthetics: Locum registrar, 138; Registrar, 59, 436
    Cardiology: Locum junior registrar, 274
    Child Psychiatry: Senior registrar, 59
    Clinical Chemistry: Senior registrar, 331
    Clinical Dental Surgery: Senior registrar/Registar, 511
    Clinical Microbiology: Consultant, 411
    Clinical Pathology: Locum S.H.O. 199; Registrar, 80; S.H.O. 460; S.H.O./Registrar, 331, 460
    Dental H.S. 243, 380
    Dental officer, 43
    Dental registrars/Demonstrators, 200
    Diagnostic Radiology: Registrar, 487: Trainee registrar, 171, 615
    House appointments, 21, 199, 355, 535
    Junior staff appointments, 222
    Neurology: Registrar, 236
    Obstetrics, 21
    Oral Surgery and Dental Casualty: Registrar/Demonstrator, 59
    Orthopaedic Surgery: Locum registrar, 460
    Paediatrics: Consultant, 411
    Psychological Medicine: Registrar, 114; Senior registrar, 43
    Renal Medicine: Registrar, 436; Research registrar, 487
    Research registrar, 199
    Senior receptionist, Keats' House, 511
    Surgical registrar, 460
  Guy's Hospital Dental School
    Anatomy Unit: Lecturer, 243
    Oral Surgery: Lecturer, 80, 307
  Guy's—Maudsley: Paediatrics:
    Research associate, 411
    Registrar, 171
    S.H.O. 511
  Guy's Hospital Medical School:
    Anaesthetics: Research assistant, 460
    Anatomy: Lecturer, 243
    General Practice: Lecturer, 307
    Introductory course tutor, 588
    Junior staff appointments, 223
    Medicine: Lecturer, 460
    Pathology: Lecturer, 243
    Surgery: Research assistant, 411;
    Secretary to Professor, 669
  Guy's Hospital and S.E.M.R.H.B:
    Anaesthetics: Registrar, 222
    E.N.T. Surgery: Senior registrar, 436
    General Medicine: Senior registrar, 648
    Geriatrics: Senior registrar, 669
    Paediatrics: Registrar, 222
    Psychiatry: Registrar, 222
    Rheumatology: Senior registrar, 487
    Thoracic Surgery: Senior registrar, 487
  Hither Green Hospital, 22, 199, 355, 535
  Hume Kendall Unit: Locum S.H.O. 380
  Lewisham Hospital, 22, 199, 355, 535
  Miller General Hospital, 22, 171, 199, 535
  New Cross Hospital, 22, 199, 355, 535, 648
  Orpington Hospital, 22, 199, 355, 535, 648
  Pembury Hospital, 22, 199, 356, 536
  St. Helen's Hospital, Hastings, 22, 200, 356, 536
  St. Nicholas' Hospital, Plumstead, 199, 536
  St. Olave's Hospital, 21, 22, 59, 138, 199, 355, 436, 535
  Thamesmead: Dental practitioner, 380
Arthritis: management of (J. C. Robertson), 365
Arts Society: Exhibition of arts and crafts, 34, 109
Ashman, R. Lunch-time O'Schultzberger, 432 (C)
Asmal, A. C. Insulin glucose relationships in the periphery, 319
Astley Cooper Studentship, 615
Atheroma factor: discovery of (P. G. Davies), 447
Athletic Club
  United Hospitals sports, 377
  University athletics, 377
  v. Middlesex Hospital and St. Mary's Hospital, 376
Atkins, *Sir* H: Retirement, 568
  Sir Heneage Ogilvie memorial service address. 397
Audiovisual teaching aids, 492, 516, 556 (C)

B

Balean, O. The rites of the unmarried, 507 (C)
Barber, N. Cot death, 178
Barrow, T: Resignation, 593, 611 (C)
Bass, B. H. Guy's in the Midlands, 557 (C)
Bateman, D. N. Pathology teaching, 298 (C)
Bax, N: Guy's Hospital Gazette editorial appointment, 2, 443
Beales, J. S. M.: Consultant appointment, 593
Beamish, E. D. 455 (C), 679 (C)
Beaumont, Berenice. Child health in developing countries, 209
Bed sores: new treatment for (R. Grahame), 426
Bennett, C. J. A dog's obeyed in office, 454 (C)
  Pathology teaching, 261 (C)
Berwick, W. E.: Obituary, 563
Births, 43, 59, 82, 171, 200, 224, 243, 276, 308, 332, 380, 411, 439, 460, 511, 536, 564, 588, 617, 648, 670
Blaikley, J. B. Address at the memorial service for the late Professor S. J. de Navasquez, 235
  retirement, 175
Blaikley, V. M. Florence Taylor memorial fund, 508 (C)
Blues
  award, 264, 376
  committee, 528

Boat Club, 75 (C), 562
Barnes and Mortlake regatta, 304
Boat Club regatta, 351
Boston marathon, 561
Hammersmith regatta, 304
Head of the River race, 193
Kingston Head of the River, 193
Ladies Boat Club, 302
Lincoln to Boston Marathon, 561
London Rowing Club regatta, 113
May and Baker Challenge Trophy, 134
Reading Head of the River, 193
River Lea regatta, 304
United Hospitals bumping races, 267
University of London Head of the River, 134
University of London Women's Boat Club regatta, 41
v. Angels, 42
World Medicine trophy, 134
Bonsor, *Sir* Cosmo *and* Lady Mabel, scholarship: *See under* Sir Cosmo and Lady Mabel Bonsor scholarship
Bournemouth and Wessex Annual Dinner, 532
Boxing injuries, 260 (C)
Bradbrook, I. D. Paternity testing at Guy's, 249
Brake, Reg: Death, 228
Brewin, T. B. How much of the stress due to cancer is avoidable? 630
British Association: Annual meeting, 461 (P)
British Dental Association: Annual congress. Guy's Alumni luncheon, 254
British Diabetic Association (J. G. L. Jackson), 322
British Medical Association. *The new general practice*: 2, 423 (R)
British Postgraduate Medical Federation: Paediatics course, 72, 532, 661
British Society for Social Responsibility in Science: Conference, 661
See also Guy's Society for Social Responsibilty in Science
British Standard Time, 590 (P)
Broido, A. 593
Bruckner (G. L. Davies), 362, 408 (C)
Brysson-Whyte, B: Appointed Principal Nursing Officer, 652
The nurse and the community, 122
Bulbeck, Dinah. Typographical errors from an unnamed hospital, 19 (C)
Burfoot, A. H. Guy's and its community, 6
Burns, T. H. S. The rites of the unmarried, 481 (C), 555 (C)
Butterfield, W. J. H: Appointed Vic-Chancellor, Nottingham University, 175
Guy's and Thamesmead, 89

C

Cambridge University
Pass lists: M.B. 82, 438
University of London, M.B. 515
Cancer: how much of the stress is avoidable? (T. B. Brewin), 630
Canoe Club, 645
Cardew, B: Obituary, 502
Cash, Joan E. *Physiotherapy in some surgical conditions*, 258 (R)
Casualty project (H. Holt *and* F. Windle), 542
Central venous catheterisation (P. Pitt), 572
Changes of Address, 43, 59, 82, 114, 171, 200, 224, 243, 276, 307, 332, 380, 411, 439, 460, 488, 511, 536, 564, 588, 617, 648, 670
Chapel: Service of lessons and carols, 640
Chaplain: a hospital (R. Kempster), 127
Charity sports afternoon, 221, 264
Chartered Society of Physiotherapy: Pass lists, 22, 114, 356, 439
Child care: aspects of, and the community (G. F. Vaughan), 29
Child health in developing countries (Berenice Beaumont), 209
Child negligence, 357 (P)
Children: mentally handicapped, 246 (P)
Chilvers, C. D. Pathologists' lament, 431 (C)
Choir, 220 (C)
Christian Discussion Group: Meetings, 48, 297
Christian Union: Carols and Christmas music, 640
Christmas arrangements, 653
Christmas boxes, 644 (C)
Christmas concert: Review, 214
Christmas Show 1970: Review, 27
Christmas Show 1971, 640
Clarke, C. A: Royal College of Physicians appointment, 570
Clinical Day 1971, 143, 220 (C)
Clinical lectures, 591 (P), 641 (C)
Closed circuit television (I.L.E.A.), 516
Clothing appeal, 611 (C)
Clubs' Union Ball, 662 (C)
Clyma, Elizabeth: Fellowship award, 280
Cohen, S. Malaria: Research news, 142
Colman, A. Lawn Tennis Club, 129 (C)
Community dentistry (D. W. Johnston), 98
Community teaching unit (P. M. Higgins), 94
Conjoint Board
Pass lists: L.R.C.P., M.R.C.S., 223, 276, 438, 617
Contraceptives: free, 514 (P)
Cooper, D. K. C. A solution? 55 (C)
Cot death (N. Barber), 178, 240 (C), 263 (C)
Coulter, S. (M.S.R.), 422
Covill, F. J. Medical care delivery in Japan, 49
Crabbe, W. A. Front surgery, 406 (C)
Cricket Club, 271, 326 (C), 374 (C), 435, 485
Inter-Hospitals Cricket Cup, 329, 379
2nd XI, 301
tour, 456
v. Ashstead, 301
v. Carnegie, 301
v. Dover, 328
v. Dragonflies, 329
v. H.A.C., 330
v. Hampstead, 379
v. Horsham, 241
v. Kent University, 328
v. King's, 329, 355
v. London Hospital, 271
v. M.S.S., 378
v. Madhatters, 410
v. Mayfair, 377
v. Mote, 410
v. Nomads, 435
v. Past, 378
v. Putney, 271
v. Reigate Pilgrims, 329
v. St. Mary's, 379
v. Southgate, 410
v. Stoics, 301
v. Wanderers, 271
Crime and the nurse (K. Simpson), 654
Crolla, J. Sport nouveau, 38 (C)
Curley, J. P.: Appointed Deputy Hospital Secretary (Patient Services), 359
Curwen, M. P. Questions and answers (Thamesmead symposium), 104
Cutler, R. Soft boiled egg-heads? 39 (C)
Cutler, T. P. White coats for students, 429 (C)

D

D.E.S. Consultative document. *See under* Student unions: Financing
Davidson, M. Nurses' lament, 431 (C)
Davies, G. L. The music of Bruckner, 362
Random reflections, 498
Davies, P. G. Discovery of the atheroma factor, 447
Davis, H. C. Christmas Mass, 17 (C)
Day, L.: Appointed Students' Club bar steward, 593
Death (M. Pembrey), 594, 622 (P), 641 (C), 662 (C)
Deaths, 59, 82, 84, 243, 276, 308, 356, 411, 439, 460, 511, 564, 617
Debating Society, 164
Dental Ball, 500, 532

Dental care of the handicapped child in the community (J. Nagel *et al*), 339
Dental School
annual clinical meeting, 34, 143, 220 (C)
conservative dentistry course, 171, 511
dental scholarship, 652
new students, 619
Primary F.D.S. course, 274
travelling scholarships, 28
Dental students: recruitment (D. J. Neill), 432 (C)
Dermatology prize, 640
Diabetes Symposium, 310 (P), 314
Dismorr, R. The rites of the unmarried, 427
Dissecting Room:
annexe, 494, 556 (C)
redecoration, 491, 556 (C)
Doubleday, F. N.: Obituary, 255
Drage, Stew. A plea from the Soccer Club, 130
Drug industry, 44 (P)
Dudley, J: Retirement gift, 220 (C), 482 (C)
Dyson, Mary. Research news: Ultrasound, 229

E

East Anglian Dinner, 190
East Kent Reunion Dinner, 144
East Midlands Reunion Dinner, 182
Egan, D. F. Medical aspects of adoption, 184
Electives, 46
Emery, A. E. H. *Elements of medical statistics*, 424 (R)
Engagements, 332, 564
Erskine, D. The ward sister, 610 (C)
"Eumatic, P. N." More, more Ron, 55 (C)
Evans, P: Retirement, 539
Evelina Children's Hospital: Fire, 175
Examinations: medical, 513 (P), 557 (C), 566 (P)

F

Faculty of Radiologists: Pass lists, 82
Farnsworth, Molly. Salmon, 166 (C)
Fellowships *and* Studentships, 223, 280, 570, 615, 652
59 Club, 75 (C)
Folb, P.: Research project, 118
Football. *See* Soccer Club
Football injuries: professional, advance in the treatment of (A. Woolstone), 233
Forbes, P. Follies Thamesmead, 408 (C)
Forge, Violette: Appreciation, 47
Fox, J. E. M. White coats, 643 (C)
Friends of Guy's Hospital, 65, 141
Front surgery, 358 (P), 406 (C), 431 (C)
Fullerton, Jane M. Pathology, 325 (C)
A short history of New Cross Hospital, 3
White coats for students, 428 (C)

G

Gardiner, P. A. White coats, 642 (C)
General Medical Council, 115 (P)
Genito-urinary tract: acute infections (E. Latimer-Sayer), 388, 455 (C)
Gleeson, M. J. Name the boat, 75 (C)
Golding-Bird Medals and Scholarships, 141
Goldman, M. J. *Principles of electrocardiography*, 287 (R)
Golf Club
Hospitals Cup, 241
London University championships, 272
v. President's team, 330
Goulder, T. J. D.E.S. consultative document on students' unions, 644 (C)
Grahame, R. New teatment for bed sores, 496
Grant, M. Nurse training on the wards, 531 (C)
Greville Studentship, 223
Guinness Stroll, 1971, 204
Guild of Ex-patients, 65, 141
Guy, Thomas, 528
Guy's and its community (A. H. Burfoot), 6
Guy's and Thamesmead (W. J. H. Butterfield), 89
Guy's diary, 2, 26, 45, 62, 86, 116, 140, 176, 202, 227, 246, 281, 310, 334, 359, 490, 522, 538, 567, 591, 623, 652
Guy's Hospital
bomb scare, 567
car park attendant, 516
postal code, 313
reseach projects, 118, 142, 229
security guards, 277 (P), 373 (C)
Guy's Hospital—St. Thomas's Medical History Prize, 398
Guy's Hospital Gazette
contributions, 66, 641 (C)
editorial changes, 2, 111, 443, 462
Guy's Hospital Medical School
Astley Cooper studentship, 615
basement excavations, 443
new students, 618
research projects, 118, 142, 229
Guy's Hospital Nurses' League: Sir Cosmo and Lady Mabel Bonsor scholarship, 570
Guy's Hospital Pupil Nurse Training School, 374 (C)
Guy's Hospital Reports, 48, 570
Guy's Hospital Society
Bournemouth and Wessex dinner, 532
East Anglican dinner, 190
East Kent reunion dinner, 144
East Midlands reunion dinner, 182
Midlands dinner, 557
South Wales and Monmouthshire: Annual meeting and dinner, 62, 65, 257
Guy's Society for Social Responsibility in Science: Meetings, 608

H

Haematology multiple choice, 404, 412
Haigh, Eileen: Appointed Chief Nursing Officer, 248
Hallam (née Weaver), Marny. Tiptoe through the Nursing Officer, 40 (C)
Hampson, Lynne. Do you know we have a President? 192 (C)
Fill up your cups, 506 (C)
Students' reaction to the D.E.S. Report, 643 (C)
Women, sherry and medicine, 580 (C)
Hand, foot and mouth disease at Thamesmead (Monica Nath), 100
Hastings Horseman, 534
death, 476
Hays Wharf: Fire, 443
Health food shops, 381 (P), 454 (C)
Helliwell, P. J. Guy's choir, 220 (C)
Henderson, J. R. Who discovered insulin? 315, 480 (C)
Hewish, P. Communication, the way to democracy, 327 (C)
Guy's part of the University? 167 (C)
Higenbottam, T.: Retirement as Sports' Editor, Guy's Hospital Gazette, 111
Higgins, P. M. A community teaching unit, 94
Higgs, F. D: Appointed Physician Specialist, British Solomon Islands, 628
Hilda and Ronald Poulton Fellowship, 223
Hockey Club, 58, 534
Hospitals cup, 133, 242
Junior Hospitals cup, 169, 198
London University six-a-side competition, 645
Spirochaetes' Easter tour, 270
Spirochaetes v. Freshers, 586
Spirochaetes v. Old Tauntonians, 665
v. Bexleyheath, 665
v. Gravesend, 646
v. Honorary Artillery Company, 584
v. Imperial College, 561
v. Kingston G.S. 646
v. Maidstone, 585
v. Romford, 78
v. St. Mary's, 646

v. Teddington, 586
v. Wallington, 79
v. Woking, 58
Women's Club v. L.S.E. 664
Holt, H. *and* Windle, F. Casualty project, 542
Homosexuality, 537 (P)
Honor Oak Park, 664
clubhouse, 328
Horoscope, 553
Hospital chaplain (R. Kempster), 127
Hospital information, 21, 43, 59, 80, 114, 138, 171, 199, 222, 243, 274, 307, 331, 355, 380, 411, 436, 460, 487, 511, 535, 564, 588, 615, 648, 669
Hume Kendall Trust, 639
Hunt, T. *Selected writings of Sir Arthur Hurst*, 483 (R)
Hunter-Craig, C. Front surgery, 406 (C)
Hurst, *Sir* A. *Selected writings;* edited by T. Hunt, 483 (R)
Hyams, D. E. Health is not economic, 17 (C)

I

Ian Howat Memorial Prize, 335
Insulin: who discovered? (J. R. Henderson), 315, 452 (C), 480 (C)

J

Jackson, J. G. L. The British Diabetic Association, 322
Japan: medical care delivery (F. J. Covill), 49
Jefferies, P. M. The responsibilities of the ward sister in training the nurses, 125
Jennett, W. B. *An introduction to neuro-surgery*, 36 (R)
Johnson, B. D: Death, 641 (C)
Johnston, D. W. Community dentistry, 98
Jones, B. J. M. Guy's part of the University? 167 (C)
Joseph, J. Research news: Ultrasound, 229
Joseph, M. C. The ward sisters, 642 (C)
Joyce, E. Security guards, 373 (C)
Judd, Lucinda L. White coats, 262 (C)
Junior Hospital Doctors' Association, 85
Junior Staff Committee, 617

K

Kaufman, H. Obituary, 607
Kauntze, R: Retirement, 415
Keats, John, 37 (C)
Kempster, R. Christmas boxes, 644 (C)
A hospital chaplain, 127
Mozart, 37 (C)
Kidger, T. White coats, 262 (C)
Kilby, J. V. *and* Kilby, Ursula, E. The ward sister, 580 (C)
Kilby, Ursula E. *See* Kilby, J. V.
Kilpatrick, S: Resignation as Editor, Guy's Hospital Gazette, 2
Knott, N. J. Not cricket? 326 (C)

L

L., P. N. In the York Clinic, 530
Ladies' Association, 65, 141
Annual general meeting, 166
cookery book, 570
Lamson Tube system, 313
Langdon, C. G. Clubs' Union ball, 662 (C)
Latimer-Sayer, E. Acute infections of the genito-urinary tract, 388
Lawn Tennis Club, 129 (C)
Lawrie, R. S. Wills Library, 300 (C)
Lessof, M.: Appointed Profesor of Medicine, 248 clinical lectures, 641 (C)
London, P. S. *See* Proctor, H.
London Bridge: *Goodbye London Bridge* (E. A. Penny), 479
London: University of, degrees, 515
Pass lists: B.D.S. 82, 487
M.B. 331, 487, 669
M.D. 223, 276, 380, 487, 617
M. Phil. 588
M.S. 617, 669
Ph.D. 223, 276, 380, 487, 588, 617

M

M., N.S. More time, gentlemen, please, 409 (C)
McColl, I.: Appointed Professor of Surgery, 623 (P)
MacDonald, R. I. Who discovered insulin? 453 (C)
McGlone, J. P. C. Students' Club Council on the D.E.S. 643 (C)
McGlone, Marie. Appeal for clothes, 611 (C)
McHardy-Young, S. Missing heart sounds record, 581 (C)
Mac Keith, R. Lecture: Children, parents and doctors, 46
Mac Keith, R. *and* Wood, C. *Infant feeding and feeding difficulties*, 348 (R)
MacKenzie, I. The ward sister, 663 (C)
McLeod, N. S. *Our glittering tower*, 282
MacManus, Emily, 54 (C)
Linda Titley, 642 (C)
Malaria: Research news, 142
Maloney, Amanda: Death, 204
Mann, G. "The rites of the unmarried", 426 (C)
Marijuana, 278 (P)
Marriages, 46, 243, 488, 511, 536, 564, 617, 648
Marshall, P. Short white coats, 453 (C)
Medical firms, 416
Medical Illustration Department, 592
Merivale, W.: Death, 84
memorial service, 84
memorial service address, 177
obituary, 87
Midlands Dinner, 557 (C)
Moss, Ann V. Wrist cutting, 347
Mozart, W. A. 37 (C)
Music Club
concert, 221
concert calendar, 297
concert review, 214, 253, 300 (C)

N

Nagel, J. *et al.* "Where our caravan has rested" *or* Dental care of the handicapped child in the community, 339
Nash, O. *Bed riddance*, 540 (R)
Nath, Monica. Hand, foot and mouth disease at Thamesmead, 100
Navasquez, S. J. de: memorial service, 142
memorial service address, 235
obituary, 120
Neill, D. J. Recruitment of dental students, 432 (C)
New Cross Hospital: A short history (Jane M. Fullerton), 3
New Guy's House
lifts, 375 (C), 644 (C)
redecoration, 86
Newfoundland: an outline (N. R. T. Pashley), 67
Newland, P. M. The dietary treatment of renal disease, 518
Newsam, J. E. *and* Petrie, J. B. B. *Urology and renal medicine*, 608 (R)
Nobel Prize Multiple Choice Questions, 501
Noble, E. C. Who discovered insulin? 452 (C)
Noise, 116 (P)
Notices, 34, 48, 72, 110, 129, 144, 221, 232, 297, 323, 338, 364, 398, 421, 500, 528, 532, 570, 608, 639, 661
Notley, R. G.: Appointment, 359
Nurse and the community (B. Brysson Whyte), 122
Nurse: a, what is? 6, 40 (C)
Nurses and nursing, 191, 238
age of entry, 403
Briggs Committee, 403

careers advice, 558
Changing times, 505
child visitors, 449
communication, 482 (C), 531 (C)
Crime and the nurse, 654
educational requirements, 403
examining, 425, 478
gifts, 259
Introduction to nursing, 483 (R)
management courses, 324
marriage, 638
meals, 219
non-nursing duties, 53
profession, 292
pupil nurse training, 374 (C)
Responsibilities of the ward sister in training the nurses, 125
salaries, 73
Salmon structure, 108, 165, 166 (C), 298 (C), 371, 580 (C)
State Final pass list, 200, 439, 669
technology, 582
training, 33
university students, 660
ward sister, 580 (C), 610 (C), 642 (C), 663 (C)
ward teaching, 529, 531 (C)
weekend working, 346
working hours, 73, 606
Nurses' Home : Rebuilding, 118

O

O., J. A little insight into the Hastings horseman, 554
Obituary :
W. E. Berwick, 563
B. Cardew, 502
F. N. Doubleday, 255
H. Kaufman, 607
W. Merivale, 87
S. J. de Navasquez, 120
Florence Taylor, 295
Ogilvie, *Sir* Heneage : Memorial service, 281
memorial service address, 397
Oliver, Dame Beryl. *The British Red Cross in action*, 348 (R)
Opie, Evelyn A. Some more on Salmon, 298 (C)
"Opportunistic infection" : Research news (P. Folb), 118
Osborn, J. 220 (C)
visiting professorship, 46
Oxford University
Pass Lists : B. M. 82, 331, 438
D.M. 380
University of London M.B. 515
Oz Trial, 414 (P), 454 (C)

P

Paediatric Department : Aspects of child care and the community (G. F. Vaughan), 29
Paediatric Research Unit, 61 (P)
Paediatrics Course : British Postgraduate Medical Federation, 72, 532, 661
Papers ; by Guy's men, 138, 224, 244, 331, 356, 411, 511, 536, 588, 648, 670,
Parental Anxiety : the prevention of (R. W. Smithells), 205
Park : the, 309 (P)
Pashley, N. R. T. Newfoundland—an outline, 67
Pass Lists :
Cambridge University :
M.B. 82, 438
Chartered Society of Physiotherapy, 22, 114, 356, 439
Conjoint Board :
L.R.C.P., M.R.C.S. 223, 276, 438, 617
Faculty of Radiologists, 82
Oxford University :
B.M. 82, 331, 438
D.M. 380
Royal College of Obstetricians and Gynaecologists :
F.R.C.O.G. 223
M.R.C.O.G. 487
Royal College of Pathologists, 82, 223, 380
Royal College of Physicians of the U.K. :
F.R.C.P. 276, 487
M.R.C.P. 223, 331, 669
Tropical medicine diploma, 487
Royal College of Surgeons of England :
F.F.A. 223, 276, 617
F.R.C.S. 82, 223, 380, 487
School of Dental Hygiene, 356
Society of Apothecaries : D.I.H. 82
State Final, 200, 439
University of London :
B.D.S. 82, 487
M.B. 331, 487, 669
M.D. 223, 276, 380, 487, 617
M.Phil. 588
M.S. 617, 669
Ph.D. 223, 276, 380, 487, 588, 617
Passim, 1, 24, 44, 60, 83, 115, 139, 173, 201, 225, 245, 277, 309, 333, 357, 381, 413, 441, 461, 489, 513, 537, 565, 589, 621, 649
Paternity testing at Guy's (I. D. Bradbrook), 249, 298 (C)
Pathology and Bacteriology : Integrated course, 516
Pathology teaching, 261 (C), 283, 298 (C), 325 (C), 326 (C), 431 (C)
Patients
child visitors, 449
name labels, 247
nursing care, 482
Pembrey, M. Death, 594, 662 (C)
Pennefather, Marguerite E. *and* Tanner, Elizabeth R. Physiotherapy in preventive medicine, 418
Penny, E. A. *Goodbye, London Bridge*, 479
Personal, 43, 59, 82, 114, 171, 200, 224, 243, 276, 307, 332, 356, 380, 411, 439, 488, 511, 536, 564, 617, 648, 670
Petrie, J. B. B. *See* Newsam, J. E.
Phlebotomy : Student survey, 627, 633 (C)
Physiotherapy in preventive medicine (Marguerite E. Pennefather and Elizabeth R. Tanner), 418
Physiotherapy School
autumn ball, 421, 570
London inter-hospital swimming gala, 563
Pickering, D : Consultant appointment, 416
Pietroni, R. White coats, 262 (C)
Pitt, P. Central venous catheterisation, 572
Surgeon in Nepal, 424 (R)
Plowman, D. Grants to clinical students, 327 (C)
"P.N. Eumatic". More, more Ron, 55 (C)
Pond, J. B. Research news : Ultrasound, 229
Poulton, Hilda *and* Ronald : Fellowship, 223
Powell, M. P. The rights o the unmarried, 507 (C)
Powell-Jackson, P. Preventive medicine in the Himalayan foothills, 288
Premarital sexual intercourse, 382 (P), 426 (C), 454 (C), 481 (C), 507 (C), 556 (C)
Private Guy, 671
Prizes, 200, 204, 335, 398, 640
Proctor, H. *and* London, P. S. *Principles of first aid for the injured*, 370 (R)
Psychiatric take-in, 444
Psychiatry teaching, 589 (P)
Puzinowski, G : Death, 347

Quizzes
Christmas 1970 brain teasers : Answers, 35

R

R., M. S. Hastings horseman killed, 476
Nobel prize multiple choice questions, 501
Singular effusions, 422
Radio Guy's (D.R.B.M. Young), 576
Radiologists : Faculty of, pass lists, 82
Radiology multiple choice questions, 451
answers, 458
Rag : Students' cup final, 85
Recknell, Jean, Miss Linda Titley, 506 (C)
Reekie, I. Cricket Club, 374 (C)
Reeves, G. Multiple choice questionnaires, 54 (C)

Reid, Carolyn. Communication, 482 (C)
Renal disease: dietary treatment of (P. M. Newland), 518
Residents' Bar: Closure, 141
Residents' Play, 34, 48
  records, 62
  Waiting for McAddle, or Oh! what a lovely ward, 145
Reviews:
  British Medical Association.
  The new general practice: 2, 423 (R)
  Joan E. Cash. *Physiotherapy in some surgical conditions*, 258 (R)
  A. E. H. Emery. *Elements of medical statistics*, 424 (R)
  M. J. Goldman. *Principles of electrocardiography*, 287 (R)
  Sir A. Hurst. *Selected writings;* edited by T. Hunt, 483 (R)
  Introduction to nursing, 483 (R)
  W. B. Jennett. *An introduction to neurosurgery*, 36 (R)
  R. Mac Keith *and* C. Wood. *Infant feeding and feeding difficulties*, 348 (R)
  O. Nash. *Bed riddance*, 540 (R)
  J. E. Newsam *and* J. B. B. Petrie. *Urology and renal medicine*, 608 (R)
  Dame Beryl Oliver. *The British Red Cross in action*, 348 (R)
  P. Pitt. *Surgeon in Nepal*, 424 (R)
  H. Proctor *and* P. S. London. *Principles of first aid for the injured*, 370 (R)
  J. V. Smart. *Elements of medical statistics*, 287 (R)
  D. Stafford-Clark. *Five qustions in search of an answer*, 370 (R)
Reynolds, D. A.: Consultant appointment, 570
Rhodes, D. Front surgery, 406 (C)
Rickett, J. 59 Club dinner, 75 (C)
Ricknell (née Addison), Jean. Miss Florence Taylor, 260 (C)
Rites of Erythrocytes, 231
Robertson, J. C. The management of rheumatoid arthritis, 365
Royal College of Obstetricians and Gynaecologists
  Pass lists: F.R.C.O.G. 223, M.R.C.O.G. 487
Royal College of Pathologists
  Pass lists, 82, 223, 380, 669
Royal Colleges of Physicians of the U.K.
  Pass lists:
    F.R.C.P. 276, 487
    M.R.C.P. 223, 331, 669
    Tropical medicine diploma, 487
Royal College of Surgeons of England
  Pass lists:
    F.F.A. 223, 276, 617
    F.R.C.S. 82, 223, 380, 487
Rudge, C. J. *and* Thomas, C. J. The Rudge-Thomas syndrome, 610 (C)
Rugby Club, 18 (C), 166 (C)
  Angels v. Sutton IV, 560
  Artists v. London Scottish, 647
  Artists v. Old Wimbledoneans, 667
  ball, 14
  Boat Club v. Angels, 42
  Cup final rag, 85
  Junior Hospitals' cup, 169
  Kent seven-a-side tournament, 273
  Middlesex seven-a-side tournament, 273
  United Hospitals cup, 56, 111, 168
  United Hospitals seven-a-side tournament, 560
  v. Bromley, 510
  v. Cambridge, 559
  v. Charing Cross Hospital, 77
  v. Loughborough Colleges, 647
  v. Metropolitan Police, 76
  v. Mountain Ash, 667
  v. Old Askeans, 533
  v. Rosslyn Park, 666
  v. St. Bartholomew's Hospital, 76, 111
  v. St. Mary's Hospital, 130
  v. Sidcup "A", 612
  v. Sutton Swallows, 559
  v. Tredegar, 584

S

Sailing Club, 304
  regatta, 306
St. Christopher's Hostel, 337, 444
St. Olave's Hospital
  medical firm, 248, 327 (C)
  patient care, 117
Salmon, L. F. W: Academic successes, 373 (C)
Saumarez, R. C. Viscosity receptors in the aortic arch, 466
School of Dental Hygiene
  Pass lists, 356
Schultzberger, A. Lifts in New Guy's House, 375 (C)
  "La Spitsia", 240 (C), 298 (C)
  Swallow this, 409 (C), 434 (C)
Schultzberger, Constance, 679 (C)
  Arnold: the truth, 434 (C)
  Whatever happened to the Wills Library? 508 (C)
Scott, P. Of cabbages and weeds, 454 (C)
Sebel, P. S. Triple helices and metabolism, 474
Security guards, 277 (P), 373 (C)
Sex education, 225 (P)
Sharp, H. C. Guy's Rugby, 18 (C)
Sheeran, W. M. Boxing injuries, 260 (C)
Simpson, K. Academic successes, 373 (C)
  Crime and the nurse, 654
  Paternity testing, 298 (C)
Simpson, M. A. How to judge, 557 (C)
  Multiple choice questioned? 74 (C)
  A plain man's guide on how to fail pathology, 326 (C)
  U.S. study tour, 359
Singular effusions (M.S.R.), 422
Sir Cosmo and Lady Mabel Bonsor Scholarship, 570
Smart, J. V. *Elements of medical statistics*, 287 (R)
Smith, D. O. Political insecurity, 37 (C)
Smithells, R. W. The prevention of parental anxiety, 205
Snodgrass, G: Consultant appointment, 416
Soccer Club, 130
  Governors' shield, 304
  Hospitals Cup final, 196
  v. Bart's, 613
  v. Charing Cross, 112
  v. Hugh Symons XI, 510
  v. Icarus, 509
  v. The London, 668
  v. Middlesex, 131, 668
  v. Old Malvernians, 509
  v. Royal Dental Hospital, 131
  v. St. Thomas's Hospital, 131, 132
  v. South Essex, 20
Society of Apothecaries
  Pass lists: D.I.H. 82
South Wales and Monmouthshire Guy's Hospital Society: Annual meeting and dinner, 62, 65, 257
Southwark Cathedral choir, 221
Spastics Society, 61 (P), 232, 500
Spector, R. Multiple choice questionnaires, 54 (C)
Spicer, R. Acute infections of the genito-urinary tract, 455 (C)
Spit: the, 240 (C), 262 (C), 263 (C), 387
Sport, 20, 38 (C), 39 (C), 41, 56, 76, 111, 130, 168, 193, 241, 264, 301, 328, 351, 376, 410, 435, 456, 484, 509, 533, 559, 584, 612, 645, 664
Sports Day, 328, 354
Squash Club, 113, 196, 456, 484, 534, 587
Stafford-Clark, D. *Five questions in search of an answer*, 370 (R)
  Gazette, 20th November, 1971, 641 (C)
Stokes, J.: Research Fellowship award, 280
Stokes, Adrian: Memorial Fellowship, 223
Starke, I. The music of Bruckner, 408 (C)
Strube, G. Front surgery, 407 (C)
Stubbs, D. Multiple choice questionnaires, 39 (C)

Student Medical Education Committee, 609
elections, 279
phlebotomy meeting, 663 (C)
Student unions: Financing, 621 (P), 624, 643 (C)
Student Voice, 174 (P)
Students: New entry, 618
Students' Bar, 409 (C), 432 (C), 442 (P), 593, 611 (C)
Students' Club, 59, 192 (C)
annual general meeting, 110, 167 (C)
book exchange, 117
council, 72, 117, 228, 434, 643 (C)
presidential election, 110
Students' grants, 327 (C), 336
D.E.S. review, 203
increases, 280
Surgical take-in: Rota, 540
Swimming Club
annual club gala, 613
London Inter-Hospital Physiotherapy School gala, 563

T

Table-Tennis Club
ladies' evening, 79
mixed doubles championship, 170
singles championship, 352
U.L.U. league matches, 352
v. Mr. Pringle's team, 353
Tanner, Elizabeth R. *See* Pennefather, Marguerite E.
Taylor, Florence: Death, 260 (C)
memorial fund, 508
obituary, 295
What is a nurse? 40 (C)
Teaching at Guy's, 413 (P)
Technicians' strike, 386
Tewfik Prize for Surgery, 335
Thamesmead, 83 (P)
Community dentistry (D. W. Johnston), 98
A community teaching unit (P. M. Higgins), 94
Guy's and Thamesmead (W. J. H. Butterfield), 89
Hand, foot and mouth disease at Thamesmead (Monica Nath), 100
Questions and answers (M. P. Curwen), 104
Thamesmead symposium, 89
Thamesmead teach-in, 107
Thamesmead Town Show, 387, 408 (C)
Thamesmead week, 104
Theatre Club, 229, 313
annual general meeting, 528
Christmas show 1970 (Review), 27
The Knack, by Ann Jellicoe, 86; Review, 216
Summer production: Three one-act plays, 399
The Talisman of Set, by Anthony Robert (Review), 15
Thomas, C. J. *See* Rudge, C. J.
Tilley, J. S. Anaerobic respiratory cycles in man, 445
Titley, Linda: Appreciation, 583, 642 (C)
retirement, 506 (C)
Tower block, 63, 282, 349 (C)
Triple helices and metabolism (P. S. Sebel), 474

U

Ultrasound: Research news, 229
United States of America: towards a national health service (H. Windsley), 524

V

Vaughan, G. F. Aspects of child care and the community, 29
Vickers, K. M. Keats, 37 (C)
Violence, 441 (P)
Viscosity receptors in the aortic arch (R. C. Saumarez), 466

W

Walton, R. G. Come home—otherwise we won't forgive you, 166 (C)
War on Want dinners, 359
Warwick, R. 74 (C)
Anatomy department, 556 (C)
Editor, *Gray's Anatomy*, 47
Honorary Secretary, International Anatomical Nomenclature Committee, 47
Mr. Dudley: Retirement fund, 220 (C), 482 (C)
2nd M.B. examiner, Hong Kong, 176
2nd M.B. party, 18 (C)
Water Polo, 77, 614
v. Imperial College, 112
v. London, 132
v. Mary's, 78
v. St. Mary's III, 614
v. St. Thomas', 614
What kind of doctor? (Review), 279
Wheeley, M. St. G. Easter concert, 300 (C)
Nursing experience for housemen, 531 (C)
O'tis cramped in the lift, 644 (C)
White, Betty: Appointed Principal Nursing Officer, 652
White coats, 262 (C), 384, 428 (C), 453 (C), 591 (P), 592, 642 (C), 652
Students' Club Council poll, 534, 443, 463
Whitson, June A. You can take it with you, 557 (C)
Whyte, B. Brysson. The nurse and the community, 122
Pupil nurse training, 374 (C)
Williams, A. Cot deaths, 240 (C)
Williams, P.: Editor, *Gray's Anatomy*, 47
Wills Library, 245 (P), 300 (C), 508 (C)
noise, 116 (P)
Windle, F. *See* Holt, H.
Windsley, H. Towards a national health service in the U.S.A., 524
Wittgenstein, L.: Plaque, 359
Women in medicine, 580 (C)
Wood, C. *See* Mac Keith, R.
Wooldrige Physiology Prize examination, 443
Woolstone, A. Advance in the treatment of professional football injuries, 233
World Sausage Eating Championship, 500
World War II, 565 (P)
Wotton, B. Bermondsey's backstairs, 349 (C)
Wrist cutting (Ann V. Moss), 347

Y

York Clinic, 530
Young, D.R.B.M. Radio Guy's, 576

Published by the Committee of Guy's Hospital Gazette and Printed by the KENTISH TIMES LIMITED, 22, North Street, Bromley, Kent.

GUY'S HOSPITAL MEDICAL SCHOOL THE WILLS LIBRARY

GUY'S HOSPITAL GAZETTE

EDITOR N. D. S. BAX

SPORTS CORRESPONDENT T. W. HIGENBOTTAM

NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TWO SHILLINGS VOLUME 85 NUMBER 2151

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Welcome into 1971. Last year contained much to disquiet. The Vietnam War drags on; the troubles in Ireland are far from resolved; race became a reason for physical violence with the visit of the Springboks; the Middle East is still in turmoil; four students were killed by State Troopers at Kent University in the United States of America. The great Frenchman, de Gaulle, died.

Our environment steadily becomes more devastated. The Americans dumped poison gas on the sea-bed.

Nine hundred thousand babies were born in Great Britain last year. Most of them will live. Many other babies in the world died of malnutrition last year. More will die this year.

We love our neighbours a little less than a year ago.

Let us hope that this year sees us developing a greater sense of corporate responsibility. There were scant few examples in the last year of man's real progress. Most "progressive" steps are retrogressive for some people. Action must be taken before we are personally affected by noise and filth. Lethargy usually shows poor returns. It is to be hoped that Mr. Peter Walker and his ministry will prove themselves worthy guardians. The present discontent which permeates hospital staff of all grades must be resolved as a matter of priority.

An Addition

Within the very near future, included in each edition of the *Gazette*, will be a "News in Brief" column. We feel this is necessary

because by far the majority of readers are away from Guy's and very rarely hear any up-to-date information about what is happening within Guy's. Indeed, many people within Guy's are unaware of what is going on about them. The editorial staff is being expanded slightly to assist with this project.

Resignation

We announce with regret the resignation of Dr. Stewart Kilpatrick as Editor. Although he has been working on the house for the past few months, he has managed to find time to maintain the standards of the *Gazette*. We thank him and wish him success in the future. He is succeeded by Mr. Nigel Bax.

Apology

To all of you patiently awaiting the solutions to the Brain Teasers we apologise. There is insufficient space to print them here. They will appear in the next edition.

GUY'S DIARY

JANUARY

4	M	1.00	Clinical Lecture. Dr. CAMERON. "The Nephrotic Syndrome."
7	Th	1.00	Clinical Lecture. Mr. MURRAY FALCONER.
8	Fr	1.00	Clinical Lecture. Dr. LESSOF.
11	M	1.00	Clinical Lecture. Mr. KINDER.
12	Tu	1.00	Clinical Lecture. Dr. GRIMBLE.
14	Th	1.00	Clinical Lecture. Dr. DOROTHY EGAN, Principal Medical Officer, Greater London Council.
15	Fr	1.00	Clinical Lecture. Professor BUTTERFIELD.

A Short History of NEW CROSS HOSPITAL

by

Jane M. Fullerton, M.B., B.Ch., D.P.H., F.C.Path.

"Without History a man's soul is purblind, seeing only the things which almost touch his eyes".

Fuller—"Holy and Profane State", 1642.

Public hygiene, although cultivated by the Egyptians and organised in the Mosaic laws and practised by the Greeks and Romans to a high degree, was rather haphazard until bacteriology demonstrated possible methods of spread and prevention of disease.

In modern times we tend to believe that we move fast in the wake of new discoveries. The work of Pasteur in 1861 and Koch and Cohn in 1876 overthrew the theory of spontaneous generation, and was rapidly followed by the appearance of many Fever or Isolation hospitals throughout Western Europe.

The South Eastern Fever Hospital, administered by the Metropolitan Asylum's Board, was opened in 1877 and consisted mainly of temporary wooden buildings to accommodate 500 patients. In 1904-6 this was replaced by a permanent building of twelve two-storey blocks with a central administrative building and a Nurses' Home.

In 1930 control of the hospital was transferred to the Local Authority, although it continued as a Fever Hospital.

In 1939 plans were made to add 120 beds by the erection of two isolation blocks on the South side (now the Dental Auxiliary Training School), and an extension to the Nurses' Home. However, these were not completed, as in 1941 during the air raids there were four direct hits on the hospital. The first fell on the then Block II (now 3A) and killed five of the staff; the second, third and fourth destroyed parts of Block 10, the Nurses' Home and the Administrative Block respectively.

This closed the hospital until 1952, although the buildings were used during the intervening period as a decontamination unit, a cleansing station, storage and despatch unit for the Southern Group Laboratory, the latter coming under the Factories Act. Two wards were used as a day Nursery.

In 1952 the title New Cross General Hospital appeared for the first time. Doctor Barbara Morton was invited by the Bermondsey

and Southwark Hospital Management Committee to open a ward for Female Chronic sick which she staffed from the Bermondsey Medical Mission Hospital. Towards the end of the year there were 102 beds, including two Medical Wards, under the supervision of Dr. Kenneth Maclean, and a Matron had been appointed.

By 1956 there were flourishing Casualty and Physiotherapy Departments, a branch laboratory of the St. Olave's Group Laboratory was established, the new theatres were opened along with Surgical Wards and supporting Out-Patient Clinics in Dermatology, Medicine, Surgery, Gynaecology and E.N.T.

The Enrolled Nurses' Training School was opened in 1953.

The next important stage in the history of New Cross came in 1965, when the hospital was taken over by the Guy's Hospital Board of Governors. During the past few years the Poisons Unit and the new Breast Unit have been opened.

The history of this hospital reflects the changing face and progress of medicine over the past 100 years, particularly in relation to the influence of vaccination, immunisation, antibiotics and improved nutrition. Between 17th and 31st March, 1877, one hundred and nine cases of smallpox, of varying degree of severity, were admitted to the hospital. Can one imagine the need for 600 fever beds in each of the eight areas of London today all full to overflowing? This was the situation right up to the early days of World War II.

Looking at the records of 1877 one wonders how many pathologists today would care to perform regular autopsies on cases of haemorrhagic smallpox, fulminating diphtheria, streptococcal septicaemia, miliary tuberculosis, acute nephritis with scarlet fever and puerperal sepsis, even with rubber gloves, which were not invented until 1894 by William Stewart Halstead of Baltimore?

It is of interest to quote from case notes of patients admitted to the South Eastern Fever Hospital:—

> A case of Variola haemorrhagia admitted 17th March, 1877 : "W. A. Male aet 24. For five weeks previous to first symptoms of smallpox, he had been under treatment as an out-patient at the Brompton Hospital, for phthisis, from which five of his family had died . . . . mulberry coloured spots appeared on his cheeks and neck, they were also present on the arms, chest and palpebral conjunctivae, these were unaccompanied with any elevation, the skin being perfectly smooth . . . . he died ten minutes after being carried into the receiving room".

An old exercise book records post mortems done in 1890 with deaths from such varied diseases as Typhus, Typhoid fever, Diphtheria, Scarlet Fever with Septicaemia, Nephritis associated with Scarlet Fever, and Puerperal sepsis.

Three extracts suffice:—

"A.T. aet 38 exp. 3rd October, 1890, admitted on 1st October, with a history of eight weeks' illness during the early part of which he was being treated for lead poisoning, his occupation being that of a painter. After admission, his temperature was never very high, 100 being the highest noted . . . he had a severe haemorrhage on 2nd October, dying the next day . . . from enteric fever".

"J.A. aet 3 admitted 4th March expired 5th March, 1891 . . diphtheritic. Incubation 18 hours . . . a ricketic child, tibiae bowed. Extensive deposit of membrane on both tonsils, fauces, pharynx and upper surface of the palate which was infiltrated. Epiglottis covered with a thick layer of membrane . . . Larynx —there was a continuous thin layer of membrane covering whole interior of larynx which grew thicker as it descended down the trachea, it spread down through the bronchi and into its divisions . . .".

E.G. aet 25, admitted 29th April, expired 30th April, 1870. Suppurative peritonitis following septic endometritis . . .
Peritoneum, well marked and recent peritonitis, general and purulent. There were several ounces of yellow pus, collected chiefly in the Pouch of Douglas. The inflammation was most marked in the pelvis, and the ovaries and Fallopian tubes were covered with thick yellow lymph.

Uterus, etc. The (os) uteri was patulous; the uterine mucous membrane congested. The uterine cavity was larger than normal, and contained an elongated body (about $1\frac{1}{2}$ inches long) attached at one end to the fundus . . . the Fallopian tubes were congested, the fimbriated ends being intensely injected. It seems probable that in this case the body in the uterine cavity, whatever its nature, had set up a septic endometritis which had led by extension through the tubes to the purulent peritonitis".

Now we do not see such cases and who knows the future of modern hospitals? The present pattern of diseases might disappear with the advent of new discoveries and the soaring Tower Block may become as much an anachronism as a 600-bedded fever hospital which was built so confidently 100 years ago.

Guy's and its Community

by

A. H. Burfoot, B.A., F.H.A.

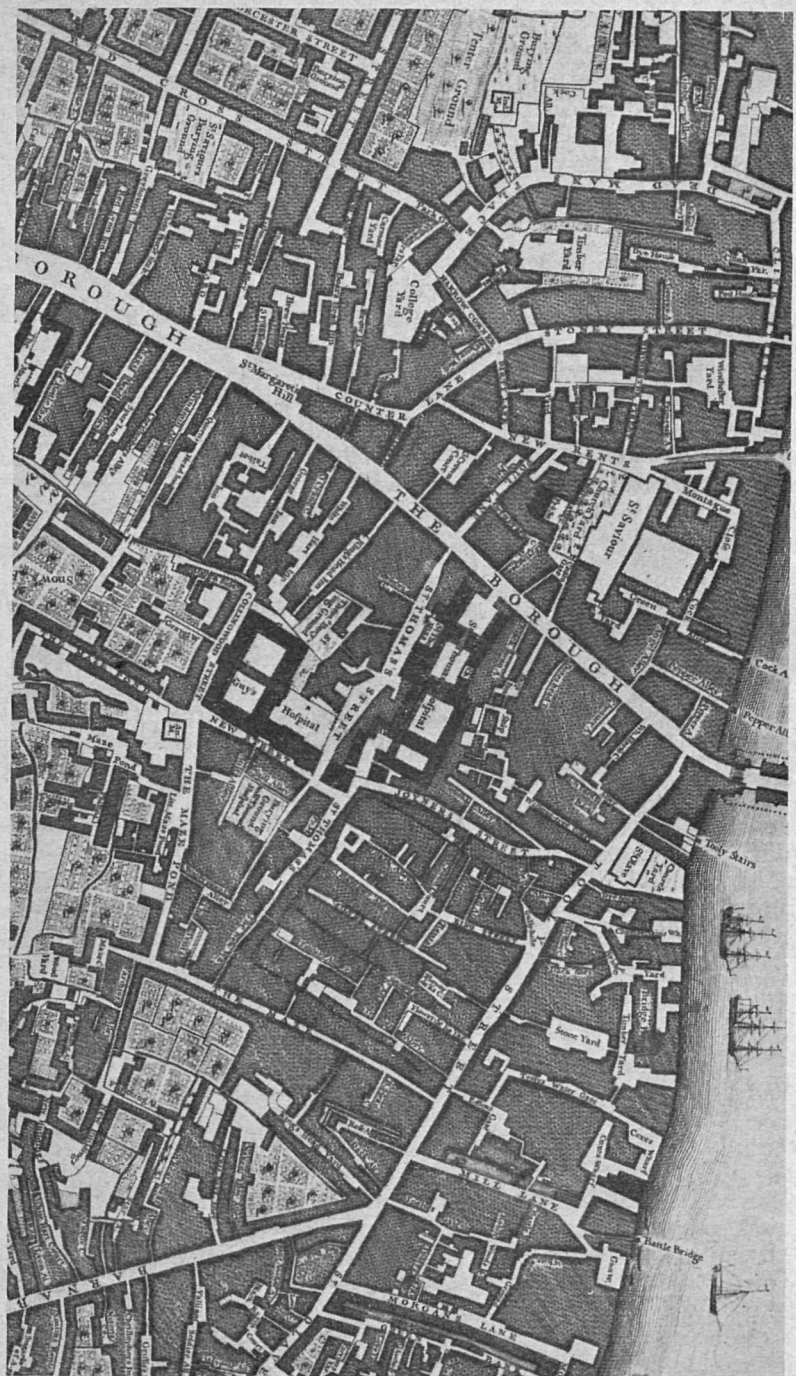
The Questions

Who are the people we serve and where do they come from? How many of them are there? Have they particular needs which do not show up in national averages? How nearly do we meet their total hospital needs? To what extent do we link with our other partners in the Health Service in providing total health care? Can the ideals of the National Health Service—"a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness"—ever be achieved within the existing constraints and what are these constraints? Have the objectives of the Health Service ever been clearly defined? What other parts of total health care lie outside the National Health Service? Where does teaching of medical and dental students come into the picture and what further constraints, if any, does it add?

All these and many other questions are relevant to the subject of "Guy's and its Community". This paper cannot hope to answer all these questions in depth or even to answer some of them at all. But it can briefly sketch out what is known of the various communities Guy's serves, the constraints within which it works and perhaps some brief ideas as to how it could move more surely towards the ideal which the National Health Service Act set.

Historical

Traditionally Guy's patients came from the old Southwark, and especially from the Borough. Guy's and St. Thomas's were the United Borough Hospitals. Guy's was the offspring founded initially to care for the poor chronic sick and lunatics whom St. Thomas's could not treat. It first served the sick of the rumbustious early 18th century with the coaching inns of The George, The White Hart, The Queen's Head, Spur Inn and The Nag's Head and many others cheek by jowl between Mr. Guy's Hospital and the highway leading to London Bridge. Along this street trade and travellers converged upon the southern entrance to the City of London. Southwark was the southern bastion of the City, and around it were the market gardens which fed the City and the slaughter houses where herds of livestock were killed to provide its meat. In the 19th century it rapidly became a borough of warehouses and tenements criss-crossed by the loping arches of the new railways which drove St. Thomas's from its original site to the dignity of its present frontage to Parliament


THE BOROUGH
COUNTER LANE
Tenter Ground
Tenter Ground
College Yard
Trinity Yard
Trinity Yard
Hospital
Hospital
Stone Yard
Horse Ferry
Horse Ferry
Horse Ferry

and Westminster. As well as Southwark, Guy's served the people of the tiny houses of Bermondsey set among hop warehouses and showrooms, leather warehouses and a jumble of small factories abutting Dockland and the Thames wharves. The scene had not changed a great deal when the Second World War brought both devastation and the opportunity to replan and rebuild.

Regrouping

Early in the post-war years the National Health Service was launched, and in the succeeding years there has been a gradual awakening to its ideals and to a new place for the teaching hospitals. Regional boards brought some order to the diffused and varying standards of hospital service in the country. The South-East Metropolitan Regional Hospital Board led the way in London in helping its teaching hospitals to be among the first to receive formal recognition of their responsibility for meeting the total range of a community's hospital needs and broadening the clinical scene against which teaching was undertaken.

In October, 1965, the hospitals of the Bermondsey and Southwark Group Hospital Management Committee were transferred to Guy's. St. Olave's was a mainly acute hospital with some geriatric beds and an active psychiatric unit. It was an integral part of the Dockland community of Rotherhithe and was held by its people in considerable affection. New Cross Hospital had been originally a fever hospital of the old London County Council before its wartime closure and subsequent development for a limited number of acute specialties initially staffed by Guy's nurses and doctors as well as providing active rehabilitation and geriatric beds. The Dunoran Home at Bickley had beds for 37 young chronic sick and a limited number of terminal patients drawing its patients from Bermondsey and Southwark. With the Evelina Children's Hospital in Southwark Bridge Road already managed by the Board, the overall bed complement of the Group, including Guy's, became rather less than 1,600 (including beds for private patients).

Establishing the Facts

By 1965, after 20 years of post-war change in the old Boroughs of Bermondsey, Southwark, Deptford and Camberwell, and one had a clear idea of the real extent of the area these hospitals served or of the numbers of people who lived there or whether their needs were being adequately met. Professor W. J. H. Butterfield had in that year carried out an out-patients' survey for Guy's itself which had revealed that in the period 1951 to 1961 nearly 70 per cent of its out-patients came from beyond the immediate area. It also hinted at the extent of self-medication or chemist care. But it did not attempt to define Guy's own district, and when the enlarged group of hospitals was formed, the Board declined to give a precise indication of the immediate area which they served. The need to prepare a development plan for the group as a whole, was clear, and the need to

ensure that the Board could meet its obligation to provide clinical facilities for the teaching of students in its associated medical and dental schools was compelling. So it was decided to carry out an operational research survey which would attempt to outline Guy's "district" on the map, calculate as precisely as possible its existing and future population, estimate its need for beds and other hospital facilities and assess the service to a wider area as well as finally attempting to relate the service provision to the teaching requirement.

Overcoming the Constraints

This decision was taken against a background of increasing co-operation between regional board and teaching hospital in planning the hospital services for London as a whole. By 1965 a real advance had been made in overcoming the practical problems which the National Health Service Act of 1948 had created. This charged the regional hospital board with overall responsibility for planning the provision of hospital and specialist services, including those provided by a teaching hospital within its region, while at the same time making boards of governors of teaching hospitals directly responsible to the Minister for the provision of hospital and specialist services. In that year at a meeting of the four metropolitan regional hospital boards and the London teaching hospitals, Mr. Kenneth Robinson set his seal on a system of four joint consultative committees for London, one for each regional segment. These were purely advisory and reported back to their constituent members for action on their recommendations for the development of hospital and specialist services in their segment. Significant was the involvement of the university through the deans of the medical schools and of both local authorities and general practitioners through nominated representatives. Because those forming the committees themselves or their working parties were either board or medical committee chairmen or senior board members and chief officers, agreement at the advisory level made implementation more likely to be achieved. The attendance of Ministry of Health observers brought in central authority and the implication that financial allocation would coincide with general planning agreement. If for no other reason than this it was sensible that a survey of the type which Guy's had in mind should not be undertaken in isolation, and King's, also faced with a larger grouping, the Maudsley Hospital (their post-graduate neighbour), and the South-East Metropolitan Regional Hospital Board became partners in commissioning the survey which was undertaken by the Royal Institute of Public Administration.

Achievement

The report which is now on the point of publication, has successfully identified the primary catchment areas of both Guy's and King's College Hospitals and calculated with a high degree of accuracy the present population and future trends. It has also defined secondary and tertiary catchment areas. It has established a practical dividing line between the catchment areas of Guy's and its neigh-

bouring groups. It has taken special account of the anticipated residential development on the 140 acre site of old Surrey Docks. Its definition of a primary catchment area has been that area in which more people look to the immediately adjacent hospitals for treatment than to those of any other hospital groups. The extent to which patients are prepared to travel to other areas to receive treatment has been clearly shown for even in parts of the primary catchment area it may happen that perhaps only 40 per cent of patients are treated by the local hospital group, while perhaps 30 per cent may be treated by a second group and another 30 per cent by a third. Even more important in view of the discussions on the Second Green Paper, it establishes without doubt that a board of governors' catchment area may bear no relation at all to existing local authority boundaries. King's catchment area for instance sits firmly astride the boundary between Southwark and Lambeth, and draws patients in large part from both boroughs. The survey estimates that nearly half of Guy's patients come from outside its primary catchment area, while King's, on the other hand, draws more than two-thirds from its immediate locality. This information dramatically emphasises the problem of planning the hospital and specialist services in London in conjunction with those services now provided by local authority, and the great difference between London and provincial teaching hospitals where understandably the latter will be the major unit in its region. The survey has found its most difficult task the relationship between clinical facilities and teaching needs, and has been forced to suggest that this is a sufficiently complex problem for a separate survey. It has also been unable within the resources it has available, to establish whether the pattern of health needs in the catchment area differs significantly from those of the country as a whole. Finally from the facts which it has established, the survey makes recommendations for beds to meet the estimated needs as they now exist for hospital treatment by the community in the primary catchment area of the Guy's Group of Hospitals. These will be the starting point for discussion with region and Department of Health.

Wider Responsibilities

So much for Guy's and its immediate community. A London undergraduate teaching hospital has a wider responsibility which spreads beyond its immediate community. It will, in association with its regional board, provide a regional service in certain specialties. Guy's is, for instance, one of the regional centres for radiotherapy; through its joint unit with the Maudsley Hospital for neurosurgery; for intermittent dialysis; for kidney transplant. But a teaching hospital has also a duty, as well as an overriding need, to be a centre for research and to have on its staff men and women who in one or more fields may lead the way in the development of their specialty. These are the pacemakers who lead the teaching hospital to provide what may be a metropolitan, national or on some occasions international service. At Guy's cardiac surgery, for instance, has been one such specialty. Against these differing levels of provisions, the intricacy of the problem of planning hospital and specialist services in London

is emphasised and additionally complicated by the needs of post-graduate teaching in the postgraduate hospitals which appear in their own specialty to provide the same three levels of service. They meet a local specialist need and provide a metropolitan or regional and national specialist service as a necessary complement to their specialised postgraduate training.

I referred to the meeting with the Minister of Health in 1965, when the joint consultative committees were set up to co-ordinate planning between individual regional hospital boards and the teaching hospitals within their segments of London. This was only the first stage towards rationalising a variety of what could be competing interests, and the next step was the setting up by Mr. Robinson in 1967 of the Joint Working Group for London. This again was an advisory body linking together representatives from the four consultative committees under an independent chairman appointed by the Minister (Dame Albertine Winner) and charged with looking at hospital service and specialist provision which cross the metropolitan regional boundaries in London and advising consultative committees. The membership of this Group included the four Metropolitan Regional Hospital Board Senior Administrative Medical Officers (with Dr. James Fairley as Medical Secretary), representative Secretaries of the London Undergraduate and Postgraduate Teaching Hospitals, University representation (currently the Vice-Chancellor), as well as a Local Authority Medical Officer of Health and the Secretary of the Inner London Local Medical Committee and Clerk of the Inner London Executive Authority representing the General Practitioners. It, too, is attended by officers of the Department of Health. In this Group is perhaps the first practical move towards co-ordination of planning the health services of London even though its concern its primarily with hospital services.

Review

It is convenient at this stage to review the extent to which this paper has so far answered some of the questions which were posed at the beginning. Guy's immediate community lives mainly in the northern half of the London Borough of Southwark and the northern tip of Lewisham. The area it covers is about $5\frac{1}{2}$ square miles, and its population is about 150,000. Probable residential development in the old Surrey Docks could more than offset the anticipated decline in the rest of the area. A large proportion of its people live in the new blocks of buildings which Southwark has put up over the last few years. Twenty-four per cent of the population are children (up to 14 years), 32 per cent are in the age group 15 to 39, 32 per cent are in the age group 40 to 64, and 12 per cent are 65 or over. The present bed provision appears adequate to meet teaching needs as they are now known. Outside its own immediate community, Guy's serves a wider population which has been estimated as the equivalent of a further 100,000 people. As its own immediate community is also served significantly by other hospital groups, so it serves in other areas the general needs of a significant proportion of other communities. In this lies the planners' nightmare. There is no tidy pat-

tern of complete care for a defined community, but a clear responsibility for a limited area and a recognisable responsibility for a much wider parish. Can such a picture ever be changed by administrative action, and even if it could, would this be desirable? There is a clear need to ensure that a Board's teaching responsibilities can always be met, but so long as these are incapable of precise definition, it is equally difficult to relate them to a specific number of beds or other facilities. The part played by a teaching hospital in meeting regional needs in more specialised treatment must obviously continue. The Todd Report on Medical Education has in mind the administrative fusion of the hospitals as well as of the medical schools which form a "twinned" pair. The general opinion of those people at present concerned with the management of the hospitals appears to be that the monster organisations which such action would produce are far too large for good management. Their overall catchment areas would have no clear community links and would be no more than a "carve up" of a number of boroughs without relation to travel routes and patients' convenience or to the organisation of community care by local authorities. In the ideal plan which emerges from the reports and papers of the last few years, London teaching hospitals would be fewer and situated in the right places. They would be large enough to provide clinical facilities for an intake of 200 medical students a year. They would be adjacent to a multi-faculty institution. The London borough boundaries would be redrawn to coincide with tidy catchment areas which in turn would have road and transport systems converging upon hospitals. An overall health authority would direct and control all those who provide health services in the

area in a tightly knit pattern, and it is tempting to conclude that doctors, nurses, patients and all would do as they were directed. Facts are unfortunately (or fortunately) far from the planners' dream and compromise, and co-operation seem a more realistic solution than massive reorganisation. The move towards recognition of community responsibility over the past five years or so has been marked. The London Hospital, for instance, has appointed a Development Officer for Community Services. Much more can still be achieved by the progressive education of those most closely involved in it and by the enunciation of clear principles of co-operation and good practice. It is a matter of judgment as to whether statutory reorganisation should reshape the scene or formalise new patterns of responsibility which have emerged out of the known needs. The development of a form of cost benefit analysis in the Health Service will help to steer priorities in the right way, but the overall constraints will remain for many years. Social services are already largely defined as the responsibility of local authority as an independent contractor. The other areas which impinge upon health—housing and education—are the responsibility of separate Ministries, though within the province of the local authorities.

Conclusion

From "Guy's and its Community" this paper has inevitably ranged to London as a whole, for the problems of the individual area are the problems of the whole, and from London the wide view extends to the national scene. It can be argued that a management reorganisation to provide proper community care can only follow a clear statement of objectives and principles. Those objectives and principles which emerge from public discussions to date are imprecise, and principles and means may seem confused. It has been said that there is real need to establish the objectives for community health care which are not just social idealisation, but tempered by pragmatic financial and political considerations.

It would be tempting, but outside the scope of this paper, to elaborate on realistic objectives. It is to be hoped that these will be enunciated in the further consideration which is now being given to Health Service organisation.

Summary

To sum up, this paper has in part answered the questions of who, where and how many. Preceding papers have touched on links with other partners in the Health Service in providing total health care. It has outlined some of the constraints which bring difficulty to those who are seeking to rationalise the services we and other teaching hospitals in London provide. It has avoided the temptation to draft the objectives for a system of health care which would secure the optimum physical, psychological, economic and social effectiveness of the individual in a manner which is acceptable to the individual. It has, I hope, emphasised that an undergraduate teaching

hospital serves more than one community, and while its responsibility to its local people is a mainstay of its structure, it must always have wider metropolitan or regional, as well as national, responsibilities if it is to justify its particular place as a teaching institution in the Health Service. In London its local community can rarely be related to borough boundaries. The future is still unclear, and our colleagues in other hospitals may forgive me for ending with a special pleading. A statutory existence, a direct relationship with the central authority and a direct financial allocation are, in my view, essential if a teaching hospital is to meet its research teaching and community responsibilities in the most effective way. Continued control of those funds which Aneurin Bevan described as a teaching hospital's "pocket money" provides the necessary balance of a limited freedom within the inevitable confines of a State service. A teaching hospital's name and its ability to attract to its governing body some men and women outstanding for their varied interests, background and wide experience are assets not lightly to be thrown away.

NOTICE

RUGBY CLUB ANNUAL BALL

The Rugby Club Annual Ball will take place at Quaglino's Restaurant on Thursday, 18th March, 1971. Double tickets at six guineas (£6.30) may be obtained from B. Armstrong and K. Rigg c/o East Wing, Guy's Hospital.

REVIEW

The Talisman of Set

By Anthony Robert

Simon Ramsden	DAVID JONES
Derek Sheddon	STUART WEEDON
Joan Sheddon	JUDITH WHARTON
Sylvia Sheddon	ELIZABETH ALLISTON
Clayton Atman	MARK TURTLE
Devil	KIP FAULKNER
Angels of Death	PAULA CULLEN REANA DAVIDSON KEITH FREEMAN BONNIE SIMONS

Produced by TONY SUTHERLAND

Directed by PAUL GARTELL AND ALAN TURNER

This play was an interesting experiment in audience participation and creation. The Theatre Club offered them a spine-chilling tale of Death, Deception, and the Evils of the Left-Hand Path. However, the audience wanted a Pantomime and by Friday night they got one.

"The Talisman of Set," adapted from the book of the same name by Anthony Robert (not to be confused with Tony Sutherland), contains many brilliant visual sequences, fantastic aural offerings and some incredibly bad lines. For example, the heroes are huddled together inside a protective pentangle when, ushered in by a tachycardia, some bugs arrive on stage. "Something touched me," says Mum. "They feel awful—what are they?" "Flies," replies Daughter (audience justifiably laughs).

However, the most stimulating moment of the evening came during a Midnight Black Mass when, after a brief decapitation, the Angels of Death reveal all their talents to the stage staff. This was one of the most brilliant and daring sequences to be performed at Guy's.

No theatrical evening at Guy's could be possible without the help of many backstage and technical personnel, the fine troupe of actors and actresses, and, of course, the audience which was so brave. Special thanks must go to Beelzebub for not turning up on the night.

"The Forces of Evil are abroad tonight," says the nine-fingered Professor. They certainly were not here.

NURSING SECTION

WHAT IS A NURSE ?

In conjunction with the rest of the community, nurses have recently suffered from the electricity cuts. The popular Press insisted at first that hospitals were not affected, but they were soon to learn differently.

As one coped with the inevitable chaos caused by having no lighting or heating or functional equipment for seriously-ill patients, one tended to wonder what would happen if nurses were to behave in such an irresponsible manner. Doubtless, one's comrades in the generating stations would be the first to complain. However, the question then arises as to what working to rule would mean for nurses. After all what is a nurse?

It appears that no one has yet satisfactorily described the function of nurses. Anyone working in the profession is fully aware that as well as being a competent charlady, a degree in electronics and electrical engineering is also an asset. Within these two extremes come the functions of those engaged in the profession.

Whereas it is hoped that no nurse would ever be so irresponsible as to contemplate strike action, disputes, such as the one described, certainly activate the most vindictive feelings against the trouble-makers, and certainly lead people to wonder why they should provide a service for those who act so irresponsibly. Particularly when they take the advantage of this time to try and scrounge non-urgent medical treatment. Naturally, one could never successfully strike in any case as the public would rebel.

However, given the hypothetical situation of a nurses' "work to rule", how would they begin? Would they refuse to do their own work first, or that which they do for everyone else such as cleaning, portering, etc.?

Nurses have never had their duties clearly defined and one can envisage the collapse of hospitals, if they did. Unfortunately, however, it is now becoming fashionable to distribute "Job descriptions". If these are taken too seriously by those with the inflexibility which was ingrained during their training, could it mean that the profession will one day be refusing to undertake duties which have not been allocated to them? Would it mean, in fact, working to rule?

mps

medical protection society est. 1892

Students!
Arrange membership now.
Full benefit immediately
you qualify.
Pay later at no extra cost.

Over 50,000 members enjoy

- unlimited advice
- unlimited legal aid
- unlimited indemnity

Full details from
Secretary:
Dr. H.A. Constable, Head Office
50 Hallam Street, London, W1N 6DE
Telephone: 01-580 9241
or
Regional Secretary:
Dr. P.G.T Ford, Regional Office,
30 Park Square, Leeds 1
Telephone: 0532 42115-6

CORRESPONDENCE

Christmas Mass

SIR.—The week beginning 5th December was a foul one by any standards and by Thursday evening the percentage of the population which had been stuck in lifts and tunnels, cut itself shaving by candlelight, had its operation postponed, ruined the contents of its deep freeze, and generally been mucked about in the cause of democracy had reached statistically significant proportions.

And then for a few of them a marvellous thing happened. They found themselves nearly filling Southwark Cathedral and listening to a most remarkable concert.

It will no doubt be reported in the *Gazette* more competently than I can hope to do, but as one of the older members of the audience I should like to thank the young men and women of Guy's who composed and conducted and sang and played musical instruments to the glory of God so that our frustrations were resolved and our minds "made quiet by the power of harmony."

Yours sincerely,

H. Colin Davis.

Little Mead,
Holtye,
nr. Cowden, Kent.

Health is not Economic

SIR.—Whilst your editorial "Health is not Economic" (21st November, 1970) was clearly written in good faith, it illustrates how the perpetuation of faulty attitudes can impair progress in medical education. One can only be saddened by the ignorance of the author who states that "there is no medical treatment to help or cure elderly patients crippled by strokes or other natural diseases of age" and "the only reason they are admitted is because they are unable to manage at home". Such statements suggest that the editorial-writer is not aware of the active aspects of geriatric medicine in the elderly which can be seen in his own hospital's geriatric department at New Cross. Has he had no opportunity to discover geriatric medicine at first-hand?

Modern medicine is not concerned simply with "cure", just as it is not merely technology. The medical student needs to learn how best to cope with ill old people, who make such heavy demands on the nation's Health Services, and for whom a great deal can be done. Only by producing doctors well-trained to face the sort of problems he is likely to meet frequently in his professional life can a great teaching hospital like Guy's maintain its traditions and achieve its prime educative function. That is progress too.

Medical students need to learn geriatrics. They will be welcomed by the staff of the geriatric wards at New Cross Hospital.

Yours Faithfully,

D. E. Hyams, M.R.C.P.
Consultant Physician.

New Cross Hospital,
Avonley Road,
London, S.E.14.

2nd M.B. Party

SIR,—May I through your pages congratulate the 2nd M.B. Senior Students on the Christmas Party at which they entertained many members of staff in the pre-clinical departments on Tuesday, 15th December. The hospitality was most generous, and the cabaret which followed, and which consisted chiefly of taking off members of the staff, was highly amusing and much too witty to be offensive. The whole atmosphere of the evening was most convivial and delightful. It has become something of a custom in recent years for the senior students in the pre-clinical school to entertain their teachers just before Christmas, and I hope that students realise how very much their hospitality is appreciated. I know that all members of this department who were able to attend heartily enjoyed the occasion and I am quite sure this must be the case in regard to staff in other departments. The proceedings towards the end of the evening became quite hectic, and I am sure that the students themselves must have realised how much those members of staff able to stay so late were "with them".

Yours, etc.

Roger Warwick.

Anatomy Department,
Guy's Hospital Medical School,
London Bridge, S.E.1.

Guy's Rugby

SIR,—May I please add a few observations to the recent correspondence regarding the state of Guy's Rugby?

The 1st XV are exempt from any criticism. They are a young, raw and light team battling against heavy odds; I saw them narrowly lose to an Oxford XV of vastly superior weight and experience solely because of their lack of poundage and rugby knowledge—certainly not from limitation of effort or enthusiasm.

I was, however, very disappointed to discover so many ex-1st XV players willing either to play for other clubs or to turn out socially for a lesser Guy's team—whilst still resident in the hospital. A few years ago such action would have been condemned as disloyal. Similarly, a house job was, and is, no excuse for abandoning full fitness and regular Saturday turn-out.

Perhaps it would not be inappropriate to remind them of the great debt they owe Guy's Rugby for the enjoyment and personal recognitions they received. Furthermore, they have now an obligation to return to Guy's Rugby some of the pleasure, skills and experience they gained. Dare quam accipere. I trust, however, that they will not time their re-appearance for the Cup matches and bow out again when the Cup is won.

My chief criticism lies with the policy of the Medical School interviewing committee regarding Guy's Rugby. Guys Hospital is the founder Rugby Union Club in the world. Furthermore, it has a tradition and reputation equal, if not superior, to that of any side in the country.

Guys Rugby, being a closed club, is dependent on the student intake which, in turn, is controlled by the policy of the interviewing body. Surely, they have a duty to uphold past traditions and to maintain and improve the standards set by their predecessors? How many clubs in England can boast so proud a heritage—how few can be so bedevilled by the apparent lack of interest and encouragement from above.

It would not require a great effort to restore Guy's Rugby to its pre-war position as a first-class club with a first-class fixture list. I can think of no disadvantage—but many benefits. One only has to observe the large number of consultant and resident staff who played for Guy's in their day—and their medicine has not suffered.

It remains a disturbing and depressing thought that the policy-forming body are content to preside over the gradual erosion of a great Guy's tradition. The future, too, looks grim for the influx of FIFTY new female students can scarcely improve the situation. I trust that netball goals are not scheduled for the 1st XV pitch!

The immediate revival depends upon the full support and co-operation of all rugby players at Guy's. Future prospects rely upon official policy, and I sincerely hope that they will now adopt a positive and beneficial attitude to the oldest rugby club in the world. Guy's Rugby tradition and fame has been hard won and, until recently, richly preserved. It would be poor tribute to the past, grave disservice to the future and a sad reflection on the Guy's administrative body if the present negligent trend were to continue.

Yours sincerely,

H. C. Sharp.

Lower Bury Lane,
Epping.

Typographical Errors from an Unnamed Hospital

SIR,—Whilst I am sure the selection of typographical errors were not from *Guy's*, I must say I have every sympathy for the medical secretaries who frequently decipher reports which at first sight appear to be medieval recipes for wine.

Yours sincerely,

Dinah Bulbeck,
Senior Medical Secretary.

Guy's Hospital,
London, S.E.1.

SPORT

SOCCER CLUB

GUY'S 1st XI v. SOUTH ESSEX

12th December. Away. Won 3—0.

This performance by Guy's fluctuated between the very good and the frankly moronic. The first ten minutes of the game promised great things. The forwards moved the ball about well and used the square and through pass to great effect: as a result the South Essex defence was under continuous pressure and looking extremely shaky. It was during this period that the first goal was scored: David Crafts hit an excellent shot from a short corner and Paul Duckworth was in exactly the right place to put the rebound off the goalkeeper into the right-hand corner of the goal.

For the rest of the first half the game degenerated to a very low level. Tempers rose and the entire Guy's team seemed to take leave of their senses. The defence, being invariably caught flat-footed and square and in a state of total panic, allowed the opposition to create dangerous situations from nowhere. But for two extremely lucky saves on the line when the goalkeeper had already been beaten, Guy's would have changed ends trailing.

For the first few minutes of the second half the battle continued to rage, reaching a climax when one member of the opposition was sent off after an attack on Bob Clarke, whose restraint and expression of surprise would augur well for a career on the stage!

Thereafter Guy's regained their senses. The short, accurate pass again became a feature of their play. Some first-class attacks were developed down the right of the field and it was these which resulted in the next two goals. The first was scored by Bob Clarke after the ball had rebounded off the post following a beautiful narrow angled shot from Roger Burns. The final goal was Paul Duckworth's second after a cross from the right.

These last twenty minutes illustrated just how well the team can play when people use their heads, the short pass and the right wing, who, on this occasion, was allowed more room than he has a right to expect. In the end, this turned out to be a good win against a somewhat agricultural and aggressive side.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL BOARD OF GOVERNORS

Applications are invited for the appointment of **Resident Obstetrician** (post-registration) for the period commencing 1st March, 1971, for six months. Applications together with the names of two referees or enclosing two recent testimonials should reach the Superintendent, Guy's Hospital, London, S.E.1, not later than **15th January, 1971.**

GUY'S HOSPITAL BOARD OF GOVERNORS

Applications are invited for the post of **Casualty Officer** (Senior House Officer Grade) at Guy's Hospital to commence 1st March, 1971, for a period of six months. Applicants with the names of two referees or enclosing two recent testimonials should reach the Superintendent, Guy's Hospital, London, S.E.1, not later than **15th January, 1971.**

GUY'S HOSPITAL BOARD OF GOVERNORS

Applications are invited for the post of **Resident Senior House Officer** in Anaesthetics from 1st March, 1971, for a period of six months in the first instance. Applications naming two referees or enclosing two recent testimonials should reach the Superintendent, Guy's Hospital, London, S.E.1, not later than **15th January, 1971.**

GUY'S HOSPITAL BOARD OF GOVERNORS

Applications are invited for the post of **Senior House Officer** to Nuffield House (Private Wing of Guy's Hospital) to commence 1st March, 1971 for a period of six months. Applications naming two referees or enclosing two recent testimonials should reach the Superintendent, Guy's Hospital, London, S.E.1, not later than **15th January, 1971.**

GUY'S HOSPITAL BOARD OF GOVERNORS

Applications are invited for the post of **Resident Paediatric House Physician** (post-registration) at the Evelina Children's Hospital of Guy's Hospital for a period of six months to commence 1st April, 1971. This post is recognised for the D.C.H. and consists of four months medicine and two months surgery. Applications with the names of two referees or enclosing two recent testimonials should reach the Superintendent, Guy's Hospital, S.E.1, not later than **15th January, 1971.**

GUY'S HOSPITAL BOARD OF GOVERNORS

Applications are invited for the post of **Senior House Officer** (Resident) in the Department of Psychological Medicine at St. Olave's Hospital of the Guy's Board of Governors commencing 1st March, 1971, for a period of six months in the first instance. Applications together with the names of two referees or enclosing two recent testimonials should reach the Superintendent, Guy's Hospital, S.E.1, not later than **15th January, 1971.**

GUY'S HOSPITAL BOARD OF GOVERNORS

Applications are invited for the post of **Senior House Officer** (Resident) in the Department of Psychological Medicine, commencing 1st April, 1971, for a period of six months in the first instance. Applications together with the names of two referees or enclosing two recent testimonials should reach the Superintendent, Guy's Hospital, London, S.E.1, not later than **15th January, 1971.**

GUY'S HOSPITAL BOARD OF GOVERNORS

Applications are invited for the post of **House Physician** in Child Psychiatry (post-registration) part-time at Guy's and part-time at the Evelina Children's Hospital commencing 1st March, 1971, for a period of six months in the first instance, resident or non-resident. Applications with the names of two referees or enclosing two recent testimonials should reach the Superintendent, Guy's Hospital, London, S.E.1, not later than **15th January, 1971.**

GUY'S HOSPITAL BOARD OF GOVERNORS

Applications are invited for the post of **Resident Dermatological House Physician** (post-registration) for a period of six months commencing 1st March, 1971. Applications together with the names of two referees or enclosing two recent testimonials should reach the Superintendent, Guy's Hospital, London, S.E.1, not later than **15th January, 1971.**

HOUSE APPOINTMENTS

1st March, 1971

Applications are invited for the following house appointments due to begin on 1st March, 1971. Forms of application are obtainable from and should be returned to Mrs. Webster, Administrative Assistant for Medical Staffing, Counting House, not later than **23rd January, 1971.**

The following house appointments will be for six months and normally will be open only to pre-registration candidates applying for their first appointment and not to candidates seeking their second six months' appointment.

House Physicians	4
House Surgeons	4
Throat and Ear House Surgeon	1
Orthopaedic House Surgeon	1
Gynaecological House Surgeon	1

The following house appointments will be for six months and will be open to candidates who have already completed their first six months' appointment at Guy's.

House Physician	1
House Surgeon	1

The following house appointment will be for six months and will be open to candidates who have already completed their first six months' appointment at Guy's or elewhsere:—

Children's House Physician	1
Genito-Urinary House Surgeon (or post-registration)	1

The following post-registration and S.H.O. appointments will be for six months:—

Resident Obstetrician (post-registration) 1

Neurological House Physician (post-registration) 1

Dermatological House Physician (post-registration) 1

House Physician in Child Psychiatry (post-registration) 1

Casualty Officers (S.H.O.) 4

The following post-registration and S.H.O. appointments will be for six months:—

Thorocic House Surgeon (S.H.O.) 1

Resident Anaesthetists (S.H.O.) 2

Senior House Officer to Nuffield House (S.H.O.) 1

House Physicians in the Department of Psychological Medicine (S.H.O.) 2
(to commence 1st April, 1971)

EVELINA HOSPITAL

Children's House Physician post-registration) 1
(to commence 1st April, 1971)

ST. OLAVE'S HOSPITAL

House Physician (pre-registration) 1
(preference given to second six months' candidates)

Gynaecological House Surgeon (S.H.O.) .. 1

House Physician in Psychological Medicine (S.H.O.) 1

NEW CROSS HOSPITAL

House Physician in General Medicine and Geriatrics (pre-registration) 1
(preference given to second six months' candidate)

Orthopaedic House Surgeon 1

OUTER HOSPITALS

Preference will be given to second six months' applicants for the following posts, but first six months' candidates may apply:—

BECKENHAM HOSPITAL

House Physician 1

House Surgeon (from 7th March) 1

HITHER GREEN HOSPITAL

House Physician in General Medicine and infectious diseases 1

LEWISHAM HOSPITAL

House Surgeon to Mr. Le Brun 1
Locum 14th—28th February, 1971.

House Surgeon to Mr. Cavendish 1
Locum 26th—28th February, 1971.

House Surgeon, Orthopaedics 1

House Physician to Dr. Llewellyn Smith .. 1

MILLER GENERAL HOSPITAL

House Physician to Dr. Hartley, Dr. Bassadone and Dr. Mallinson .. 1

ORPINGTON HOSPITAL

House Surgeon to Mr. Walker-Brash and Mr. Chivers 1

PEMBURY HOSPITAL

House Surgeon to Mr. Gibson and Mr. Lavy 1

House Physician to Dr. Miller and Dr. King 1

ST. HELEN'S HOSPITAL, HASTINGS

House Physician in General Medicine and Geriatrics to Dr. Irvine 1

P. J. HELLIWELL,
Superintendent.

22nd December, 1970.

PASS LIST

THE CHARTERED SOCIETY OF PHYSIOTHERAPY

Preliminary Examination

Miss D. J. Beauchamp
Miss G. M. Broad
Miss J. Brooker
Miss S. J. Brooks
Miss A. J. Dalton
Miss B. K. Dooley
Miss J. E. D. Handley
Mrs. J. R. Humphries
Miss J. A. Johnstone
Miss J. C. Lee
Miss J. Miles
Miss P. A. O'Brien
Miss C. G. Patterson
Miss V. M. L. Philps
Miss M. L. D. Pollock
Miss L. Ripley
Miss H. L. Smith
Miss A. E. Suttle
Miss E. Taylor
Miss R. P. Toone

Intermediate Examination

Miss A. M. S. Boulter
Miss S. G. Butler
Miss J. E. Carey
Mrs. P. M. Currier
Miss W. R. Gibson
Miss G. M. Hobbs
Miss J. M. Kelly
Miss V. A. Lockhart
Miss S. M. Long
Miss J. S. Mansfield-Brown
Miss I. Martindale
Miss P. A. Redfern
Miss J. Roubicek
Miss J. E. Thompson
Miss B. A. Thurlow (Credit)
Miss C. M. Wakefield
Miss M. C. D. Watt (Credit)
Miss D. S. Willis

We would like to remind our readers that all copy for inclusion in the "Gazette" must be received eight days before publication date.

Copy may be sent to us c/o The Front Lodge, Guy's Hospital.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, please indicate whether or not this should be published.

Personal notices one shilling per word (pre-paid) (minimum £1. 1s. 0d.).

Non-subscribers will pay £1. 1s. 0d. (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

EDITOR N. D. S. BAX

SPORTS CORRESPONDENT T. W. HIGENBOTTAM

NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TWO SHILLINGS VOLUME 85 NUMBER 2152

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Smoking

In 1962 the Royal College of Physicians warned us of the dangers of smoking. The effect was transient, people cutting their consumption for only a few days. The continuous barrage of advertising from the cigarette companies continued, whilst the report was little advertised except perhaps by a few words at a general practitioners' surgery or to a patient in hospital. The latest report from the Royal College of Physicians indicates that very few of the public have stopped smoking as a result of their 1962 report. Indeed, progressively more people have started smoking.

After the first report many people thought that provided they did not smoke "too many" cigarettes they would be safe. It has now been stated emphatically that there is a risk for all smokers. A gruesome statistic is that the present report attributes 15 per cent of deaths in males aged between thirty-five and sixty-four years of age, to be directly related to cigarette smoking. This is very probably an underestimation.

The use of time and money treating people who have an illness related to cigarette smoking is very great. In addition the economy of the country is in danger of being affected by a sickness of such a large scale.

Since the 1962 report, a pitiful £100,000 per year has been spent by the Government on anti-smoking advertising. This is swamped by the amount spent by the cigarette companies. However, the Government is obviously in a dilemma. It raises over one thousand million pounds a year from taxes on smoking, a revenue equal to

60 per cent of the running cost of the National Health Service between 1969 and 1970. On hearing this fact smokers may say that as they pay so much tax the cost of their treatment is more than covered. Their treatment would never have been necessary had they not smoked.

Without doubt serious steps will have to be taken to curb smoking. The choice of the method is extremely difficult because any Government action will be construed by some as an action against civil liberties. Some will ask whether it is the function of government to legislate in such a way as to deprive people of their pleasures, however lethal they may be. Is the medical profession becoming too emotional about the whole thing? The answer is no. Smoking is an unnecessary, anti-social, unhealthy and selfish habit.

What form should constructive help to cut down an individual's cigarette consumption take? Perhaps by raising the cost of cigarettes many times, or by legislation as to areas and times people are allowed to smoke, or persuasion, or by the creation of the image of a smoker as an anti-social person. One could legislate against advertising, but this is perhaps unacceptable. Some time ago cyclamates were banned from cordials. This was remarkable in a way because no side-effects had been observed in humans, but only in experimental animals in a grossly abnormal situation. But it was easy to ban cyclamates because there was a substitute. At present there is no substitute for cigarettes and the creation of one will do little to help.

In a free society, a method that could be successful, is by putting the message of the dangers of smoking into everybody's minds by a continuous, almost brain-washing style of advertising. A method currently used by tobacco companies in their own advertising.

Intimate Relationships

The recent B.B.C. films of this title superficially explored the relationships doctors and patients build between themselves both in and out of hospital. The final programme in the series of three was an "open discussion" between patients, doctors and James Burke.

Great emphasis was placed on good communication between the doctor and his patient. As the whole community could not exist without communications, it would seem reasonable to have some instruction available to those sectors who have to deal in specialised topics. It is perhaps thought by Medical Schools that three years on the wards and the necessity of passing some examinations bestows upon one the basic essentials necessary for communication with patients when one is qualified. This, in the majority of cases, is far from reality. Related to teaching, some of the more memorable Clinical Lectures were those in which the presentation was concise. Few lasted more than forty-five minutes, which is the length many have found most compatible with learning. One learns best from good communicators.

Another point from the last programme was the sort of care a patient said he would expect on going to a hospital. In every aspect from communications to treatment he expected his care to be first-

class. It would be interesting to know how many of the public treat people with whom they regularly come into contact and thus communicate, in a way in which they expect the doctor to treat them. No doctor would think of offering any service other than first-class, within the limitations of his expertise and equipment. However, to meet the very reasonable demands of the patient above requires a great deal of money. This is a fact the very people who demand a better service are only too willing to forget.

GUY'S DIARY

JANUARY

19	Tu	1.00	Clinical Lecture. Dr. MOYNAHAN.
21	Th	1.00	Clinical Lecture. Dr. JOINER. "Leukaemia I."
22	Fr	1.00	Clinical Lecture. Dr. CHAMBERLAIN.
25	M	1.00	Clinical Lecture. Dr. MURRAY FALCONER. "The Costo-Clavicular Compression Syndromes."
28	Th	1.00	Clinical Lecture. Dr. JOINER. "Leukaemia II."
29	Fr	1.00	Clinical Lecture. Dr. STAFFORD-CLARK. "The Trickcyclist on the Tightrope."

CHRISTMAS SHOW 1970

REVIEW

Not a great Christmas Show, but a more than adequate show, which met the mood and needs of its determinedly cheerful audience with ease. The vibrant enthusiasm of the cast was admirable, considering the uphill struggle involved in producing these shows.

The show was noticeably lacking in original or topical material; the sketches, mostly from "At Last the 1948 Show", were sound, but rather dated now that we are in the full flush of the post-Monty Python era. What originality there was lay mainly in the unifying musical talents of Mike Lavelle, whose range and ability continue to surprise and please. In the cast as a whole, indeed, we discovered widespread musical abilities on piano, drums, bass, banjo, spoons, penny whistle, proctoscope, sigmoidoscope and the flying Cusco's speculae.

The singing was effective, especially in the close harmony version of "Deep Purple"; it was perhaps surprising in 1970 to find no song less than ten years old, and most considerably older—but the standards were well done. The gang, led by Mike Lavelle at the piano, managed some agreeable jazz in the Dudley Moore mould. The cast all coped well with their material, and managed to share the spotlight with good grace.

Some items certainly deserve individual mention. The sketch on the Great Guy's Flood was notable—the writers of this commentary did well; the anonymous Counting House authors of the original circular did superbly well! Miss Dick proved to be a torch singer who turned on many members of the audience. On the first night, we must congratulate Mike Bamford on his cameo appearance in this song—a performance that was nothing short of magnificent.

Finally, one must commend Bruce Dick for his splendid contribution as ventriloquist's dummy—a mordant, biting satire on the role of a student President in the modern world.

Michael A. Simpson.

GUY'S HOSPITAL DENTAL SCHOOL

Travelling Scholarships

Attention is drawn to the undermentioned Travelling Scholarships which are now available.

Newland-Pedley Travelling Scholarship

This Scholarship will be awarded to the holder of a registrable dental qualification, who has been educated at Guy's Hospital Dental School, to enable him or her to undertake a year's postgraduate dental study at one or more Dental Schools or Colleges abroad approved by the Dental Council. The value of the Scholarship will be up to £1,000 and the actual amount of the award will depend upon whether the holder of the Scholarship proposes to spend a year at an institute in Europe or Scandinavia or whether the year will be spent in Canada or the United States. The holder of the Scholarship may be required to undertake teaching duties in this school for the academic year following that in which the Scholarship is held.

Dental Travelling Scholarship

This Scholarship has a value of £250 and is awarded every third year to the holder of a registrable dental qualification, who has been educated at Guy's Hospital Dental School, to enable him or her to study at one or more Dental Schools abroad which are approved by the Dental Council.

Both these Scholarships will be offered for award in 1971. In order that applications for the Travelling Scholarships may be considered by the Dental Council in sufficient time to enable the successful candidates to make arrangements for travel, etc., it is necessary for all applications for Travelling Scholarships for 1971 to be received by the Dean of Dental Studies by **1st February, 1971.**

The Dean of Dental Studies will be pleased to discuss the matter with anybody who is interested.

ASPECTS OF CHILD CARE AND THE COMMUNITY

by

Dr. G. F. Vaughan, F.R.C.P, D.P.M.

"Humanity at all times"—a basic tradition

Easily said, not always so easy to apply, it is the practical carrying out of this sentiment, the principle of Osler "to comfort always", that underlies what we aim to do within the hospital and more than this, within our community area.

Perhaps this is so strong in the hospital because it was one of the concepts of Thomas Guy. Our original foundation set out standards for the care of patients, especially mental patients—at that time clean straw, general cleanliness, and courtesy!—which were far ahead of the thinking of the day.

Certainly it has made the hospital quick to introduce bridges of contact with various aspects of the community such as meetings with its area doctors to discuss the service it provides, a public relations adviser, unrestricted visiting and even an admission comic for children, appointments systems for out-patients at a time when these were anything but universal, a five-day children's psychiatric ward, day surgical services, psychiatric advice for burnt children, a social medicine department, and a very active Health Visitor service, all at times when these were advances in hospital service. It was a Guy's paediatrician who long ago stressed the need to see mind and body as one. It is this awareness perhaps that has made us examine and re-examine our ethics in heart transplant and other transplant surgery, and watch so very carefully the implications of closed circuit T.V. and other teaching procedures. From their first clinical days our student nurses and our medical students are taught to see beyond the hospital—into the community—it is this which has made our newer developments so logical.

Our paediatric stature

Psychiatry has benefited immensely from the prestige and status of the general paediatric departments. These now form one of the largest paediatric centres in the country—the Department of Child Health under its senior physician Dr. Philip Evans: a thriving depart-

ment of paediatric research under the Prince Philip Professor, Dr. Paul Polani; and the Centre for Assessment of Children with Multiple Handicaps, under Dr. Ronald Mac Keith. This unit alone is now larger than the majority of teaching hospital paediatric departments. Although a recent development in the hospital, it is already a major factor in the thinking of the country's future paediatric care.

The Department of Child and Adolescent Psychiatry

It was inevitable that the psychiatric provision for children would gain from its conjunction with such lively paediatric services on the one hand and an extremely progressive Adult Psychiatric service on the other (under Dr. Stafford-Clark and Dr. Fleminger). It has enabled us to give a modern and fully comprehensive service which would not have been possible otherwise.

We are one of the largest departments in the country in terms of diagnostic numbers, but because of our small staff number we have to concentrate, and perhaps this is a good thing, on a small, highly specialised treatment and diagnostic advisory service, and a general service for our local community only. We see some 300-400 children for detailed diagnosis, a further 200-300 for psychological assessment only, and a further number for ward advice or other kinds of educational advice.

We follow the view that it is unrealistic and a disservice to build up waiting lists extending to months or over a year, so that we keep within a four to five weeks period at the most, by giving priority to our own hospital, general practitioners, and our local community area (approximately 10 per cent of our patients come from other hospitals, 25 per cent from Guy's, and 60 per cent from our local G.Ps.).

Our staff, though small, aims to support this combination of a general specialist service and a comprehensive local service (one part-time Consultant; two whole-time senior registrars; a registrar; senior house officer; three psychiatric social workers; a part-time Consultant Psychologist and two part-time senior psychologists; two part-time research psychologists; a remedial teacher; a ward teacher; and a variable number of student teachers seconded for special instruction from the London University Institute of Education).

Our patients range from a few months up to twenty-one—perhaps this should now be eighteen—but the tendency has been if anything to refer still older patients when their problems clearly stem from childhood or they are late in maturing. We also, at times somewhat reluctantly, take our turn in providing an advisory service on the needs for termination of pregnancy.

The children's psychiatric ward (seven children up to 15 years) is a further example of a community orientated service. When first opened it was the only five-day unit in this country. Children can come to it for part of the day, all day, a few days, or all week. Their mothers can come too, join in with the school or child care, sit and watch, talk to each other, or talk to the nurses. We have been fortunate from the start in having it accepted that we need a nurse to patient ratio overall of at least 1-3 and whenever possible 1-2 children.

However, we still have a major problem. The general age of children coming to us has risen progressively so that whereas some years ago the majority were children aged seven and eight, we now see very large numbers of adolescents without suitable in-patient beds to support us. My colleagues allow me to admit to the York Clinic but this is through necessity and specialised adolescent beds are needed urgently. There is also a problem within the region, because travel across country is so difficult and the local clinics are insufficient for local needs, numbers of patients come from far out in the region, particularly the Kent coastal areas. They are difficult to treat because of the travelling time involved—local services need improving.

The Triple Rôle—Treatment, Teaching, Research

We emphasise the practical application of academic theory all the time. The medical students come in two groups of 15-20 over a period of three months, late in their clinical training. During this time they attend routine out-patients, interview patients over closed circuit T.V., and attend a weekly lecture/seminar where extensive use is made of film. When necessary, interviews on the closed circuit can be recorded on videotape so that the interviewer can replay the interview to himself and we can build up excerpts for teaching. Closed circuit used in this way means that the main class can discuss particular points as they arise without disturbing, and equally important, embarrassing the patient. However, as one important part of our relationship with our community, the procedure is fully explained to the patient, who usually and rather surprisingly welcomes it. If necessary we are always ready to have the interview directly with everyone present or in private.

The growth points in the department

It would not be appropriate to set these out in detail but the following list shows the general range of themes which are now being enquired into or have been recently.

The psychiatric and psychological assessment of children damaged by thalidomide.

The diagnosis and treatment of infantile autism.

"Whole family" interviews and group interviews in psychotherapy.

Operant conditioning in anorexia nervosa.

The making of teaching films and the use of closed circuit T.V.

The recognition of battered babies in the community.

The psychological assessment of children with local brain damage and investigations of the significance of laterality.

"Painless" interviewing and short-term goal directed psychotherapy.

Depression in adolescence.

The recognition of learning difficulties as a result of birth injury or inherited maturational delay. This last is a major on-going

activity in the department and is linked with the provision of remedial teaching and trying to provide help within the school system.

The department building is a research one provided by Mr. Instone Bloomfield and his friends, and is in itself a major facility enabling these activities to be carried on. In addition we have at present a Nuffield Foundation grant and money from the Fripp Fellowship.

An exciting and challenging joint new development—the Newcomen Foundation site

Dr. Ronald Mac Keith's centre for the assessment of children with multiple handicaps has only been in operation for a few years, and yet it is now bursting out of its building. It needs new premises urgently.

Thanks to the great goodwill of a number of people, and especially the Newcomen Foundation, the site of the Newcomen School is being made available for a new centre. This is a splendid example of Guy's extending its services for the community and part of the community coming forward to make this possible. For the first time in this country we have an opportunity to bring together on one site, in buildings designed for the use to be made of them, an expanded paedriatric centre for children with multiple handicaps (funded by the Ministry of Health and Social Security), a centre for the specialised assessment of deafness in children (funded by the Inner London Education Authority), and a psychiatric centre (funded most generously by a private individual, Mr. Instone Bloomfield). The latter will function closely with the other two. It is a logical transfer of work we are already carrying out in the main child psychiatry department. For the first time expert teaching investigations and psychiatric investigations will be available together. In this way we aim to undertake research into remedial methods, which is urgently needed, and also to instruct teachers in the problems of learning disorders in children. We see this as a valuable further step in community service, bringing members of the community, in this case school teachers, into a teaching hospital for instruction and through them spreading our assistance into the community at large.

NURSING SECTION

NURSE TRAINING—HOW?

If a survey were conducted on nurse training in this country, it would doubtless show that in most of the large hospitals there is an experimental course of training under trial.

British nurse training has a very high reputation throughout the world, and a qualification obtained here will serve as a passport to almost any country. This reputation has been built over the last century, and would, one hopes, be very jealously guarded. Why then do all these new training courses seem to have as their aim and object the production of nurses who will, it seems, lack the traditional attributes of those trained in this nation?

In this day and age, it seems we are bound to have progress, although one is frequently unsure as to what this is exactly! Do we, however, have to eliminate every vestige of what has gone before?

The British nurse achieved her fame by her expertise at the bedside. The emphasis at present, however, seems to be on the theoretical aspect of the work, with the practical side being passed on to others. Looking into the future one can envisage the ward sister whose knowledge is excellent, but who, because she has never done it, is unable to carry out a fairly simple practical procedure. This sad state of affairs has occurred in other countries, and it would seem that it is doomed to happen here.

It is saddening to notice that those who have travelled abroad, return being unimpressed by the standards of nursing which they have observed; and then proceed to introduce to the training schools of this country, plans which are identical to those seen elsewhere.

It has been noted recently that one world-famous hospital—outside Britain—is unable to recruit enough students of high enough intelligence. Is this really the type of person that is required? Naturally, the nurse must be sufficiently intelligent to understand what she is doing, but frequently those with the greatest number of academic achievements have in fact the least practical ability. If the training of nurses is to aim at an education which is comparable to a degree course at university it goes without saying that the basic attributes of the profession will automatically be lost.

In addition to all this, the newly-introduced training schemes are demanding that the students spend more time in the classroom. No one, however, has contemplated how this is to be compensated, and whilst we continue to staff our hospitals with cheap student labour, this can only mean one thing, namely that the standards of care will undoubtedly fall. The nurses will then reach the end of their training well endowed with scientific facts, but never having seen how patients should be cared for properly.

Is this really what is desired for this country? Surely it will mean that ward work will become even more of a frustration, and that nurses will be even more eager to leave the bedside. Who is going to care for the patients in ten years' time?

This is the dilemma in which nursing has placed itself. Is there any way in which the situation can be reversed? Or are we destined, as ever, to follow like sheep those who are past recall?

NOTICES

Guy's Hospital Residents' Play

15th—19th February, 1971

In order to satisfy the large demand for tickets, the Play may be seen not only in the Physiology Theatre (by kind permission of Professor T. N. Hunt) but also by closed circuit television in the Anatomy Theatre (by kind permission of Professor R. Warwick).

Applications for tickets (which will be available from 1st February) and any donations towards the costs of the Play should be made to: Alister Vale, Business Manager, East Wing, Guy's Hospital.

Annual Dental Clinical Meeting

The Annual Dental Clinical Meeting will be held in the Dental Department on Saturday, 6th March, 1971, and the Dental Society Dinner will be held in the evening. A resumé of the programme will be published in the "Gazette" on the 14th February, 1971.

R. D. Emslie,
Dean of Dental Studies.

Arts Society Exhibition 1971

The Arts Society is once again arranging an Exhibition of Artistic Works produced by members of Guy's Hospital. This will take place in the Gordon Museum (Medical School) from **Monday, 25th January** to **Friday, 5th February** with a wine and cheese party on the first day. If you have any paintings, sketches, sculptures, etc., you would like to exhibit, please contact Miss Margaret Hooley, Secretary of Arts Society, c/o East Wing, Guy's Hospital, as soon as possible.

Answers to Christmas Brain Teasers

Everybody lied

Because we are told that all the patients will lie to the police, we may commence by negating each of the eight false statements. This results in the following eight true statements:

(1) One of the four killed the Psychiatrist.
(2) The Psychiatrist was dead when Avery left.
(3) Blake was not the second to arrive.
(4) The Psychiatrist was alive when Blake arrived.
(5) Crown was not the third to arrive.
(6) The Psychiatrist was dead when Crown left.
(7) The killer arrived after Davis did.
(8) The Psychiatrist was alive when Davis arrived.

From the fact that each of the patients only visited the Psychiatrist once on the day of his demise and the statements 2, 4, 6 and 8 above Blake and Davis arrived before Avery and Crown. From 3 above, Davis must have arrived second; so Blake arrived first. From 5, Avery must have arrived third; so Crown arrived fourth. The Psychiatrist was alive when Davis arrived second, but was dead when Avery left third. So from 1, Avery or Davis killed the Psychiatrist. From 7, Avery is the murderer.

The number of marbles needed to construct a triangle

Unity is excluded. It is therefore the L.C.M., or the multiple thereof, of the six triangles. If we compute the L.C.M., of the smallest triangles, we see that we cannot do better than to start with the factors 2, 3, 5, for out of them we can get the triangles 3, 6, 10, 15. Since 30 is not itself a triangle, we will choose a multiple of 30. The lowest number that is a triangle is 120, but out of this number we cannot make any additional triangles. The next multiple is 210 and this is found to serve science being divisible by 3, 6, 10, 15, and is also divisible by 21 and 105, both of which represent the number of marbles needed to construct a triangle.

Dudeney's cigar puzzle

The principle of this puzzle is based in symmetry.

Whoever has to play from a perfectly symmetrical arrangement of cigars on the table must lose. If he can find room to add a cigar, then so can his opponent. The latter need only add his cigar on that point (and in the same relative orientation) which is symmetrical to the position of the first cigar, with respect to the centre point of the table. (Two points A and B are symmetrical with a point, if the C is the mid-point of the straight line joining A and B.)

It would seem then that the second player must win, since he has only to keep pairing his plays with those of the first player. But there is a circumstance which can easily be overlooked. The cigar as described can be made to stand upright on its flat end. The first player wins by placing his first cigar upright on the only unique point on the table—the centre of symmetry itself!

The Camper and the Bottle

The camper reached a point $3\frac{2}{3}$ miles upstream from his camp. He first met the bottle two miles away—the distance he could travel in 48 minutes at the net rate of $2\frac{1}{2}$ m.p.h. The bottle then floated two miles at the rate of the stream, taking 80 minutes to reach the camp. In this time the canoer, with respect to the water, went upstream some distance and then returned to his starting point (the distances and times of the two trips must be equal). The total time being 80 minutes, the upstream trip occupied 40 minutes. With respect to the banks of the stream, the canoer still proceeded at the net rate of $2\frac{1}{2}$ m.p.h., and therefore travelled an additional $1\frac{2}{3}$ miles away from his camp.

BOOK REVIEW

AN INTRODUCTION TO NEUROSURGERY (2nd Edition)

by Prof. W. Bryan Jennett (365 pp. + xiv. Illust.). London. Wm. Heinemann. £3.50.

There are so-called introductory textbooks to most subjects; they are usually ephemeral, but occasionally, like Holmes' *Introduction to Clinical Neurology*, they flourish. The appearance of a second edition of Professor Jennett's admirable book confirms that it, too, has come to stay—provided the temptation of allowing it to grow larger can be avoided.

It is easier to try to think who has least to gain from reading this book than to enumerate those to whom it should be recommended. Neurosurgery follows the nervous system into the sphere of every branch of medicine, and there is something here for everyone. For instance, the chapter on head injuries is the most informed and informative 46 pages on the subject that will be found anywhere, and should be read by anyone dealing with trauma. House physicians should read the chapters on intracranial lesions, and paediatricians the one on congenital conditions. Anyone who picks the book up will be tempted to delve into it.

No attempt is made to cover the essentials of neuroanatomy, neurophysiology, neuropathology, and the clinical examination of the nervous system, for these are the foundations of neurology and neurosurgery, and the author has wisely avoided producing a useless distillate of these subjects. He has, however, clarified certain points and misconceptions. His style is lucid, succinct, often aphorismic, and never ambiguous. The illustrations are clear and complement the text.

The preliminary chapters concern basic principles, definitions, and diagnostic essentials. There are some helpful pages on radiological and other investigations which put these tests in perspective, and give guidance about their choice and limitations. The treatment and post-operative care of intracranial lesions is considered in general and in particular. In addition to the chapters already mentioned, there is a chapter on spinal lesions, including tumours and prolapsed intervertebral discs. Neurosurgery is almost unique in having many widely differing operations which create lesions in tissues that are often not themselves abnormal. These are considered in the final chapter, and range from stereotactic surgery to chordotomy and the treatment of trigeminal neuralgia.

If you have an interest in neurology or neurosurgery, read this book from cover to cover; you will enjoy it. If you are not in this category, dip into it and you will find something useful. If you want to read further there are many carefully picked references to the most useful sources of information.

P.H.S.

CORRESPONDENCE

Mozart

SIR,—I may interest your readers to know that Mozart had a connection with at least one of the London hospitals. In the summer of 1764 the eight-year-old boy played in a charity concert in aid of the lying-in-hospital in York Road, the foundation stone of which was laid in the following year. A friend writes of him at this time—"While he was playing to me, a favourite cat came in, upon which he immediately left the harpsichord, nor could we bring him back for a considerable time. He would also sometimes run about the room with a stick between his legs by way of a horse."

Yours sincerely,

ROBERT KEMPSTER.

Guy's Hospital, London, S.E.1.

Keats

SIR,—I thought the following might be of interest: After reading Richard Church's letter in the *Times* stating that Henry Stephens, the inventor of "Stephen's Ink", shared lodgings with John Keats when they were both students at Guy's, I asked him if he could throw any light on the exact whereabouts of Keat's lodgings.

He told me that in a letter Keats wrote to his friend, Cowden Clarke (son of the headmaster of his school, and later husband of Mary Novello, sister of the founder of the great music-publishing firm), he said: "Although the Borough is a beastly place in dirt, turnings and windings, yet No. 8, Dean Street is not difficult to find; and if you would run the gauntlet over London Bridge, take the first turning to the left and then the first to the right, and moreover knock at my door, which is nearly opposite a Meeting, you would do one a charity . . . . "

Richard Church presumed that Keats meant a non-conformist Meeting House or Chapel, and told me that it was in that very spot that he himself laid the opening scene of the first volume of his trilogy, "The Porch" (published in 1937 and awarded by the French, the Femme vie Heureuse award the following year).

Mr. Church used to pass the Cathedral every day from 1911 to 1920 on his way to the Laboratory in the Custom House. Though he *longed* to be a doctor, he had to become a writer instead. He wonders if Dean Street still exists.

Yours sincerely,

K. M. VICKERS,

Staff Health Service.

Guy's Hospital, London, S.E.1.

Political Insecurity

SIR,—Politics has always been a distasteful subject to most of us in the medical and dental profession, and we have always resented being used as a political pawn.

It was for this reason that the review body was first conceived and recently reinstated. However, clever manoeuvrings between sectional interests of the professions and juggling with changes and regulations has put our future in jeopardy. The elders of our professions have been ignored with what may be disastrous long-term results. Everybody has been very gentlemanly and

put professional esteem and welfare of the patient first. We all hate suggestions of the need to use industrial action.

The new dental system of pricing may well set the clock back two decades.

Perhaps the student body is in a position of privilege. Theirs is the right to demonstrate and to attract attention by other means. Is it not time to make a concerted effort to remove our professions from the threat of political insecurity and to demand further legislation for greater long-term self-government autonomy and development with reasonable prospects of a policy of continuity. We are all heartily sick of being "mucked about".

Yours sincerely,

D. OSMOND SMITH.

Langdale,
Long Copse Lane,
Emsworth, Hants.

Sport Nouveau

SIR,—In the Christmas edition of the *Gazette,* our Sports Editor delivered a thesis on the nature and cause of student apathy towards sport at Guy's. His exposition, at first, followed principles of good sense gradually leading one to a righteous climax.

He never reached it, but in the course of his exposition made certain steam-rolling statements, one in particular which I felt could not be let go unnoticed. As an excuse for the decline of sport at Guy's he states "students are abandoning the established sports of the more 'trendy' arts societies." In one sentence he condemns himself as a rather narrow interpreter of the term art.

To one not a medical student, or doctor, but involved in technical work within the hospital, it is no wonder that the arts afford a refuge for the imagination which the medical curriculum, by its sheer volume of fact cannot readily afford.

In the art's many faces, the medical and dental student, as well as anyone else, can diversify his or her intellectual pursuits as a means of recreation from the demands imposed by science. Medicine appears to be a discipline designed to test the memory to the utmost, and although interesting for its own sake, must also demand long hours of memory work. Therefore, I personally would have thought that the growth and development of artistic activity should be a thing welcomed by students and staff alike, and not merely to be dismissed out of hand as trendy.

As a keen sporting enthusiast myself, I am not denying the importance of sport but suggest that it should be considered, as the arts, within its own context. Many of the sports at Guy's noticeably Rugby, place large demands upon the participants for supreme physical fitness, something not gained by a ten-minute trot round the gym. once a week. So, although the decline in sport is sad, it is not altogether unexpected, although some clubs [viz. Soccer] seem to be thriving—probably because the soccer club plays teams within its own class.

The growth of the "trendy" arts societies is, in a medical institution such as Guy's, not to be lamented but commended.

Yours faithfully,

JOHN CROLLA,
Research Technician, Guy's.

Paediatric Research Unit,
Guy's Hospital.

Beauty and the Ball

SIR,—Let us hope that H. C. Sharpe's letter is ignored by the interviewing body of this hospital. The medical school does not exist for the production of a 1st XV. How medical students are selected for this hospital is a close secret but many welcome the present state of the rugby club as a sign of fairer selection.

The female medical students can only improve the hospital atmosphere. Surely fifty female students is a more attractive prospect than fifteen rugby players!

Yours sincerely,

BOB FIELDSEND.

East Wing.

Multiple Choice Questionnaires

SIR,—I have recently suffered the mental ravages of four multiple choice questionnaires. Now education is not only about giving the "right" answers, but also about asking the "right" questions, at least, asking questions in the "right" way. While my answers to these M.C.Q.'s may have been less than 100 per cent correct, I feel I must also fail my elders and betters for amateur and pedestrian questions and marking structure.

First, some minor points. In medicine, all things are possible, and one must never say never. Possible and never are words to be avoided. Also, the words seldom, often, usually, etc., have no real meaning and should not be used.

Secondly, the result of a student at an examination, reflects not only his knowledge, but also his ability at examinations. This particular form of irrelevant gamesmanship rises to peak importance with M.C.Q. We should determine once and for all, whether guessing should be punished or not. Any physician who is certain of anything in medicine is fooling himself and his patients. The difference between an informed guess at an M.C.Q. and the valued judgment of a consultant is only a matter of degree. I feel that the most sensible method is that of the Part I M.R.C.P. examination. If you mark every question, or leave every answer blank, or mark answers at random, you get zero in each case. We are an anumerate profession, and this is reflected in the inability of M.C.Q. setters to apply the simple marking formula concerned. I refer them to a simple explanation in *The Lancet*, 1967, Part ii, p. 1034. I am amazed that a computer should be used to mark the answers without using a rational marking system for which the machine is easily adapted.

Thirdly, the substitution of M.C.Q.'s based on lectures for signing-in has opened up a dangerous fallacy. That is, that every word that proceeds out of the mouth of a lecturer is an absolute truth. M.C.Q.'s should be based on commonly available reputable textbooks and not the spoken ideas of one member of a hospital department.

Yours, etc.,

DEREK STUBBS.

East Wing, Guy's Hospital.

Soft boiled egg-heads?

SIR,—Dr. Nicholson might help *Gazette* readers if he defined what precisely falls into the category of "good class sport". Is Rugby and Judo U, and football and boxing non-U, and are those not so participating by definition "egg heads". Further, does "time for" indicate taking physical part in, or merely watching and cheering the others on?

In the last analysis, games activities stand or fall by their own merits, and some might hold that, say, countryside walking or participation in an archeological dig, rank no less highly than indulgence in games covered by

the blanket title of "sport". How excellence in rough and tumble sports can make a better doctor is open to debate, and certainly lack of it has no connection with dullness; indeed, many would agree that the wholly dedicated can have an attraction and usefulness uniquely their own.

Yours, etc.,

ROBERT CUTLER.

8, Lower Sloane Street, S.W.1.

Tiptoe through the Nursing Officers

SIR,—Miss Molly Farnsworth (Christmas edition) may enjoy being in the army as a C.N.O., certainly her complacency equals her failure to grasp the essentials of English grammar.

Let me tell her quite plainly, in case no one else does, that there are many trained nurses from Guy's and other hospitals who have been saddened and disturbed by Salmon. They cannot, of course, be in her group nor, I imagine, would they wish to be.

She writes of the need for progress and says the ward-sister is responsible only to her Unit Nursing Officer.

She does not add that the Unit Nursing Officer is responsible to the Senior Nursing Officer and the Senior Nursing Officer is responsible to the Principle Nursing Officer and the Principal Nursing Officer is responsible to the Chief Nursing Officer and the Chief Nursing Officer is responsible to the Chairman of the Board of Governors or, in less happy circumstances, to the Chairman of the Hospital Management Committee of the Regional Hospital Board and so on to the Department of Health and Social Security.

What sort of progress is this ?

The trained staff who nurse the patients (soon the student-nurse will be only a student and must not be put upon) are the sisters and staff-nurses. These are the people upon whom the patients and doctors depend and their humour and their devotion enable them to ignore the top structure who, they know, are helpless and useless in a real situation.

So Miss Farnsworth, get out of your swivel-chair and into the wards and see why so many nurses are leaving the profession. Wastage is now at its highest level.

Yours truly,

MARNY HALLAM (née Weaver).

19a The Esplanade,
Ryde, I.W.

"What is a Nurse"

SIR,—May I take up one point in the article "What is a Nurse" in the current issue of the *Gazette*. "It is now becoming fashionable to distribute job descriptions". If these are lists of duties for which nurses are responsible, they were in existance fifty-five years ago, probably long before and were in use twenty years ago. They were known as "Books of Work and were presented to the nurse when she went to a new ward or department. The nurse was asked to make a copy and return the book to sisters within a week. They listed the patients for whom the nurse was responsible, the daily ward duties and weekly 'Extra Work'. Many of these duties would now be classed as 'non-nursing' but most of them brought the nurse into contact with the patients and in some way contributed to their well-being. I remember a little ditty which ran 'Here's your book of work nurse, you couldn't do your hair worse, I can't think why they've sent you here again' ".

Yours sincerely

FLORENCE TAYLOR.

Flat 2
103 Blackheath Park S.E.3.

SPORT

SPORTS COMMENT

In H. C. Sharpe's letter of the last edition, an intake of fifty women medical students, was mentioned as if a crime was to be perpetrated. It should, however, be noted that for the last two years almost this number of delectable females have already been admitted. Also the dental school for several years has been admitting a higher proportion of female students than this, with few ill effects. Indeed most of the active members of the rugby club are dental students.

It is purely a personal impression, but I feel it is not the system of selection of potention medical students which is at fault, for the lack of great rugby players in our midst, but a change in the type of person who is now applying to study medicine. We are but witnessing a very subtle change occuring within our profession. Whether it is for the better or the worse, no one can tell as yet. There is, however, little point in preaching against it as it has already happened and is completely outside the control of the medical schools.

The point is taken when H. C. Sharpe states that there is little regard now for the great past and tradition of the Rugby Club. Much too little attention is paid to this aspect of the hospital. However, even at the peaks the club remained only a sideline of the hospital. It has indeed inspired many past and present members of our hospital by the enormous enthusiasm and dedication of the past great Guy's players. It is perhaps this secondary, but most important function of inspiring us by its example that is most missed today. But with the different types of students attending the hospital today it would probably be more useful to find a new means of inspiration than to attempt to maintain a 1st class rugby club.

BOAT CLUB

UNIVERSITY OF LONDON WOMEN'S BOAT CLUB REGATTA

This is the first time Guy's have ever had a ladies' crew. Great credit must be given to these girls, who have been unable to help as much as we would have liked.

(1) NOVICE IV—Lost, 1½ lengths

This was one of the first races on the programme, therefore limiting the amount of pre-race warming up. The IV were beaten narrowly by a crew from a college with a tradition of ladies' rowing behind them, who then went on to win the final.

(2) COLLEGE IV—Won Final, 6 lengths.

Perhaps it is unfair to claim this as a Guy's victory as in fac tthe IV was a scratch inter-college crew. F. Odle—one of the Novice IV however was picked to row in the crew which outclassed all its rivals.

Any girls who would like to row will be most welcome and should contact either the captain or secretary of the Boat Club, East Wing. The girls proved this term that rowing could not only be enjoyed by the fairer sex but also be done well.

CREW: Bow, R. Mitchell; 2, E. Ryman; 3, C. Marshall; Stroke, F. Odle; Cox, C. Spooner.

THE BOAT CLUB v. ANGELS

Result: 3—32

The main purpose of the afternoon was to entertain the sponsors of the Marathon IV and show them still photographs and ciné films of the row. Beechams very kindly provided the money to give all our supporters as much food and drink as they could consume and we are most grateful to them for their generosity.

As part of the entertainment a game of Rugby was staged in front of the largest crowd seen at H.O.P. for many months. The game could not in all honesty be termed a classic—although it did have its moments—thanks to some splendid refereeing by John Shorter. It started with a shock—the Boat Club were all over the Angels keeping them pinned down in their own half. After ten minutes Gilman intercepted a pass to score in the corner for the Boat Club. By half time the Angels had managed to score twice but the match was, at that time, by no means going their own way.

Whether our oranges were doped or whether the Angels became celestially inspired we shall never know, for the second half deteriorated into a procession—26 points are supposed to have been scored in that time (some Guy's teams have of course had more scored against them in both halves!). Which Angels scored, or to put it another way, didn't score was not disclosed by either the referee—who was too busy with arithmetic—or the Angels captain who was overcome with relief.

If ever the Angels would like to try their hands at rowing I am sure that we could beat them by an equally large margin.

The Angels Shine

RUGBY HOSPITAL CUP GAME

19th January at Bart's Ground, Chislehurst

ALL ARE WELCOME.

PLEASE SUPPORT OUR CLUB

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL

Applications are invited to fill an established vacancy as **Senior Registrar** in Psychological Medicine to the Board of Governors of the Guy's Group of Hospitals and the South East Metropolitan Regional Hospital Board. The appointment will be for 4 years from 1st March, 1971 with duties rotating between the Guy's Group and the Bexley Group. Applicants should have an active interest and experience in teaching and research and preferably have a higher qualification. The post, which will be reviewed annually, is subject to the terms and conditions of service of Hospital Medical and Dental staff (England and Wales). Forms of application are obtainable from and should be returned to the Superintendent, Guy's Hospital, London, S.E.1, not later than **22nd January, 1971.**

GUY'S HOSPITAL

Applications are invited for the appointment of **Dental Officer** to treat in-patients (general practitioner grade) with attendance on six sessions a week for the period 1st April to 30th September, 1971, in the first instance. The post will be subject to the terms and conditions or service of hospital medical and dental staff in the National Health Service. Forms of application are obtainable from and should be returned to the Superintendent, Guy's Hospital, S.E.1, not later than **29th January, 1971.**

PERSONAL

BATH—Associate/assistant required end of March to join three Guy's men in well equipped practice. Low seated, high gross from mainly conservative work. Private and NHS. Box No. 2/1.

SUDDEN DEATH (aged 56) of eldest of three University of London doctors. Assistant with a view needed. Golden opportunity for a young enthusiast. Dr. Lansdown, 205 Sanderstead Road, Sanderstead, South Croydon, Surrey, CR2 0PN.

CHANGES OF ADDRESS

Dr. and Mrs. James Appleyard, 20 St. Stephens Road, Canterbury, Kent.

Dr. and Mrs. M. J. Brummitt, 15, High Street, Malmesbury, Wilts.

Surgeon Rear-Admiral (D) W. I. N. Forrest, R.N., C.B., 16, Queen's Road, Waterlooville, Hants.

Bill and Denise Heald, Flat 3, 19 Morden Road, Blackheath, S.E.3. Tel: 01-852 4061.

Dr. Alan J. Kingdon, 6, Old Bridge Close, Bursledon, Hants. Tel: Bursledon 3710.

Mr. J. E. St. Pierre, "Beechcroft", Scotts Hill, Outwood, Surrey. Tel: Smallfield 2718.

Dr. and Mrs. M. D. Steyn, Andrew Nash Clinic, 136 Nelson Street, Wallsend, N.S.W. 2287, Australia.

BIRTH

WILKINSON—On 29th December, 1970 at the Royal Cornwall Hospital (Treliske), Truro, to Ivan and Jacqueline Wilkinson: twins, Graham Paul Edward and Karen Elise Victoria a brother and sister for Rorden Michael.

We would like to remind our readers that all copy for inclusion in the "Gazette" must be received eight days before publication date.

Copy may be sent to us c/o The Front Lodge, Guy's Hospital or left in the "Gazette" pigeon-hole in the East Wing.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers.

When subscribers notify the "Gazettte" of Change of Address, please indicate whether or not this should be published.

Personal notices one shilling per word (pre-paid) (minimum £1. 1s. 0d.).

Non-subscribers will pay £1. 1s. 0d. (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

EDITORS N. D. S. BAX and A. M. TURNER
NEWS EDITORS R. M. DARLING and J. LEWIS
SPORTS CORRESPONDENT T. W. HIGENBOTTAM
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TWO SHILLINGS VOLUME 85 NUMBER 2153

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

The price of progress

One of our favourite whipping boys is the drug industry. In the religion of clinical medicine a rite is to criticise the pharmaceutical industry for the persuasion of innocents into prescribing new drugs when they have no advantage for the patient over other cheaper forms of treatment, are possibly dangerous to use and a great deal more stress to the taxpayer's long-abused pocket.

Undoubtedly some of these arguments apply to some drugs, but we now have a dejected industry making its reply. After the U.K. Committee for the Safety of Drugs found against so many of the oral contraceptive tablets, the study of new means of fertility control has become a field too stony for many to harvest. Dr. Christie, the director of Syntex, recently warned that we are overtaxing the drug companies and asking of them ill-rationalised testing procedures; demands extravagant of time and expense which in the particular case of research into fertility control are smothering the attack on the problem that government cannot afford to avoid.

The prime concern of both prescriber and manufacturer is safety, but they disagree on reasonable criteria. The manufacturers must surely be right that we should concentrate more on a study on what applicability results in animals have for the safety of man than on performing many screening tests on a seemingly random selection of animals. There are two sorts of risk, firstly the documented risk that some patients will suffer known side-effects, and secondly the risk that some will suffer illnesses as yet unknown from particular drug dosage. Those risks will continue so long as we take the view that it is better to kill or injure a few and cure many than let all suffer. Perhaps we should say that drugs should not be released on the market until every biochemical effect they might have on humans is

known. Would Penicillin be on the market yet under such conditions? The risks involved depend on the disease and the treatment; in the case of pregnancy, which is fast becoming regarded in many to be pathological to society, a woman's liberty and body, the ill-effects of the only effective prophylactic are less than those of not protecting ourselves.

So we have an effective method of fertility control. The money that pharmaceutical industries say we have to invest in them to give us a better method should be spent in educating women to use it. The problem of producing one to suit women with a history of thrombo-embolic disease and unreliable memories is less acute than making contraception available to all. It is true that Government cannot afford to ignore fertility control, but their money and effort should go into giving the present method a chance of success.

Improved drugs are expensive to make and expensive to test. It is up to the doctor to minimise expense by sensible prescription, with expense a consideration. That is straightforward, although not perhaps as easy as unrationalised blame for the high cost of the National Health Service on an un-nationalised industry.

GUY'S DIARY

FEBRUARY

1	M	1.00	Clinical Lecture. Dr. HYAMS.
4	Th	1.00	Clinical Lecture. Dr. HOARE.
5	F	1.00	Clinical Lecture. Dr. MACKENZIE.
		2.15	Combined Round. Dr. GOULDING will speak on "Acute Poisoning."
8	M	1.00	Clinical Lecture. Mr. CRABBE. "Scoliosis."
9	Tu	1.00	Clinical Lecture. Dr. DOW. "Pulmonary Embolism."
11	Th	1.00	Clinical Lecture. Dr. HARDWICK.
12	F	1.00	Clinical Lecture. Mr. O'FLYNN.
		2.15	Combined Round. Mr. WATSON will give an illustrated talk on "Fungal Changes in Sickle Cell Diseases."

NEWS IN BRIEF

Miss Catherine Doughty and Professor Neill

Miss Catherine Doughty, secretary to the Dean and Sub-Dean of the Dental School for the last 11 years, is leaving on 29th January to marry Professor Neill, Sub-Dean of the Dental School and Professor in the Department of Prosthetic Dentistry. We offer them our congratulations and very best wishes.

Student Electives

Medical students planning electives abroad might be interested to know that there is now available a file containing information on various hospitals abroad which Guy's students have visited. Although the file is not vast, it is hoped that it will be built up into a permanent feature to assist students in planning electives. Those interested should see Miss Maureen O'Neill in the Physiology Department.

In addition, there is available in the Medical School Office, a list of addresses of old Guy's men living abroad, which can sometimes be useful in planning electives.

Brain Drain

We would like to congratulate Dr. Jeffrey Osborn, Senior Lecturer in Anatomy in relation to Dentistry, in the Anatomy Department, on his appointment to the Alexander Agassiz Visiting Professorship in the Museum of Comparative Zoology at Harvard University, U.S.A.

Servile Doctors?

On Thursday, 14th January, Dr. R. MacKeith gave a lecture entitled, "Children, Parents and Doctors," the first of the second series of lectures on Ethics in Biology, by the Guy's Society for Social Responsibility in Science. Although distinctly unrelated to its title, the lecture turned out to be an interesting and amusing ramble through the relatively uncharted territory of medical philosophy (a topic, incidentally, upon which Dr. MacKeith thought medical students should receive instruction). One theme which surfaced more consistently than some from the torrent of ideas produced, was that doctors should not get carried away by their own sense of importance, for they are ultimately their patient's servants, rather than vice-versa—a highly commendable notion which might be new to some of us.

Professor Warwick and Dr. Williams

Professor R. Warwick and Dr. P. Williams, both of the Anatomy Department, have been appointed new editors of Gray's Anatomy. Professor Warwick has, in addition, recently been elected Honorary Secretary of the International Anatomical Nomenclature Committee. Our congratulations to them both.

Dr. W. J. Appleyard

Dr. W. J. Appleyard, Senior Paediatric Registrar, has recently taken up a consultant appointment at the Kent and Canterbury Hospital at Canterbury. After qualifying at Guy's in 1960, Dr. Appleyard worked at St. Thomas's Hospital, the Miller Hospital, Greenwich, the Hospital for Sick Children, Great Ormond Street, and in the U.S.A., returning to Guy's in April 1969 as Senior Registrar in the Paediatric Department. He managed to find time while at Guy's to play an active part in the Junior Hospital Doctors' Association. We wish him and his family every happiness in the future.

MISS VIOLETTE FORGE

An Appreciation

I am sure there are many past and present Guy's nurses who have the highest regard and affection for Miss Violette Forge, and who would like to join with me in wishing her a very happy and active retirement following 22 years of devoted service to Guy's.

I for one shall never forget her sympathetic understanding and great kindness to me as my Lady Housekeeper, nor the meticulous way in which she carried out her duties as Warden in charge of the Nurses' Residence in Matron's House and later in the Nurses' Home.

She was a perfect hostess and friend to those in need, and at all times set an excellent example to the Nursing Staff by her calm manner, her immaculate appearance in uniform, and her attention to detail.

She also maintained excellent relationships with the members of the domestic staff, who were devoted to her.

I am sure many of us have admired over the years her delightful flower arrangements in the Chapel and on the tea tables at our League Reunions and special parties.

I am sure Miss Emily MacManus and Miss Dorothy Smith will miss her warm welcome as I shall when we visit Guy's.

May she retain many happy memories of us all and be blessed with good health in the years ahead.

Jean Recknell,
formerly Miss Jean Addison,
Matron of Guy's,
August 1953—August 1962.

NOTICES

GUY'S HOSPITAL REPORTS

Volume 119/4 has now been published. The contents are as follows :

Physique, Glycosuria and Blood Glucose Levels in Bedford.—Gillian Fowler, *et al.*

Visceral Leishmaniasis.—M. A. Q. Jamil.

Long-Term Use of Implanted Pacemakers in the Control of Complete Heart Block.—D. C. Siggers and D. C. Deuchar.

Trends in the Treatment of Obesity.—I. Macdonald.

The Adolescent Patient.—W. Warren.

One Hundred Years Ago—Select Clinical Cases.—Ralph Kauntze, Samuel Wilks.

Subaortic Stenosis induced by drug therapy in a patient with an apparently normal heart.—Hywell Davies.

Alkaptonuria.—R. C. Fieldsend and I. G. McGill.

An unusual tumour of the spleen associated with a high serum alkaline phosphatase.—R. G. Pietroni.

Orders for separate copies of this number, or for annual subscriptions to the Reports, should be sent, accompanied by an appropriate remittance, to the Honorary Treasurer, Guy's Hospital Reports, Guy's Hospital Medical School, London, S.E.1.

The special rates for Guy's men are :
Each number, 12s. 6d. ($62\frac{1}{2}$p).
Annual subscription, £2 2s. 0d. (£2.10).

GUY'S HOSPITAL RESIDENTS' PLAY

15th—19th February, 1971

In order to satisfy the large demand for tickets, the Play may be seen not only in the Physiology Theatre (by kind permission of Professor J. N. Hunt) but also by closed circuit television in the Anatomy Theatre (by kind permission of Professor R. Warwick).

Applications for tickets (which will be available from 1st February) and any donations towards the costs of the Play (payable to Guy's Hospital Residents' Play Fund) should be made to Allister Vale, Business Manager, East Wing, Guy's Hospital.

GUY'S CHRISTIAN DISCUSSION GROUP

Guy's Christian Discussion Group wishes to extend a warm invitation to all who work or study at Guy's, to meet for a series of discussions on the life of the Lord Jesus Christ as recorded in St. Luke's gospel. These meetings are held in Classroom 1A, Medical School, from 1.00—1.45 p.m. each Thursday from 21st January to 18th March. The meetings are in the nature of very informal conversation based upon the Scriptures, and everyone is most welcome.

M. J. Graveney, Secretary
(Physics Department.)

MEDICAL CARE DELIVERY IN JAPAN

by

F. J. COVILL

The main influence on Japanese culture before 1868 was Chinese. With the end of the Civil War, the defeat of the Shogunate, and the emergence of the Meiji dynasty the influence came from Europe, chiefly Germany and England. Since the war, which ended in 1945, the American way of life has left its mark, thus it is not surprising to find contributions to the delivery of medical care which have their origins in Europe or U.S.A.

Administratively there tends to be separation between the three arms of medical care, not so rigidly applied as in England, but more after the pattern of U.S.A. Most Physicians have access to hospital beds, although side by side with the voluntary system there exists the State hospitals in which the physicians are employees.

There is a State insurance system which it is compulsory to join unless medical care is assured by other means. Many large firms provide full medical care for their employees, and 50 per cent of its cost for the employees' dependents. This covers physician services and hospital use but not drugs. The medically indigent are paid for by a State welfare scheme.

PRIVATE MEDICINE

About 65 per cent of medical care facilities are private, the remainder are State operated. Private practitioners provide general medical services and hospital services to those who can afford to pay or are insured. Not everyone can afford a private physician, and the needs of these persons are met by clinics which are run in conjunction with "Health Centres", which, primarily are public health units with a minor ailments clinic attached. Serious disease is passed to specialised hospitals for treatment. Service is provided by physicians who are State employees, and this is supplemented by the purchased services of private practitioners on a sessional basis. Most general practitioners provide pharmaceutical services for their own premises.

The private practitioner practises from his own clinic, which is frequently also his home. A fee schedule is negotiated with the

government (and it seems that "negotiated" is a face saving synonym for imposed). Each service has a price, details of which are kept on a form which is submitted to the government agency monthly for payment. The scale of fees is low. Appendectomy and ante natal care and delivery are each valued at $45, the current Canadian fee being $106. A subcutaneous injection attracts a fee of 20 cents, while an I.V. injection merits 40 cents. It is not surprising that medical discontent with the fee schedule is widespread. A general practitioner must necessarily see 80 patients a day to cover his expenses, and may see up to 180, such is the pressure of work.

The doctor-patient ratio is 1—1,538. With this patient demand the quality of medical care cannot be high.

Hospitals are of two classes, private and State operated. Private hospitals may be owned by groups of physicians, trade unions, industrial enterprises, or voluntary societies. The costs in private hospitals tend to be higher and the physicians earn more. Under the State insurance scheme transport to the hospital is free where needed, the cost of the hospital care is the responsibility of the patient, but this is covered by the State insurance scheme, so that effectively it is free. There are 7,800 hospitals in Japan, 68,000 general medical clinics, and 29,000 dental clinics. Of the hospitals 5,028 are private, the remainder being State run.

TOSHIMA HOSPITAL

Metropolitan Tokyo has seven State hospitals. Toshima hospital is one of the seven. Administratively the Chief is a genial Japanese physician, Dr. Sato, who fills the role of medical superintendent. He has control of the hospital, but not clinical control of the employed physician. He is supported by a lay administrator and some 35 clerks. There are 170 communicable disease beds, and 240 general beds which was increased by 100 when the present construction was completed in November, 1970. The hospital serves a population of 1½ million; a bed ratio of 1 to 6,350 population does not suggest a high standard of medical care delivery. Nursing shortage is not peculiar to the West. Of the 211 nursing positions approved there are 70 vacancies. The 85 medical staff is short of 20, the paramedical staff of 59 lacks only five, and there are two unfilled vacancies out of 46 administrative staff.

Wages generally are low in Japan. The average monthly pay of a physician working in Toshima hospital is 188,665 yen ($517). Thus it is possible to provide patient care at the rate of 300 yen (around $3) per patient day. Out-patient attendances cost rather less than half this sum.

The facilities provided include 40 neurosurgery beds of which 15 are used for trauma, 35 paediatric beds with 25 bassinets, and 15 incubators for prematures, 40 obstetric and gynaecological beds, besides beds for orthopaedics, general, and internal medicine. During 1969 the hospital worked at 88.2 per cent bed occupancy. There is

a pathology, cytology, haematology and biochemistry laboratory. In 1969 there were 242,578 laboratory investigations at an average cost of 192 yen each (30 cents) while 58,279 X-rays were taken at an average cost of 663 yen per film ($1.70).

The oldest part of the hospital was built for communicable diseases isolation 70 years ago—and this is readily believed. The general hospital was established 25 years ago and the latest wing has been in operation for four years. In the part completed in November there are 40 premature baby units. In contrast with the decrepitude of the earlier building, the new unit is quite up-to-date with air locks and positive pressure filtered air, the most sophisticated electrical equipment amongst which was an E.E.G., E.C.G., echo oscillograph and a self-contained X-ray unit.

PUBLIC HEALTH

Public Health is managed separately from hospital and general medical services, and bears a remarkable similarity in organisation to the North American Health Unit. There are 66 Health Centres, as they are called, in Tokyo. The aim is one centre for 100,000 people, but the growth of the city has always precluded this goal being reached.

Takinokawa Health Centre is under the direction of Dr. Hongo, who is responsible for all the activities carried on by the unit, and also for its management. As health care is largely centralised in Japan the budget is determined by the government, although representations for additional supplies may be made by the Superintendent. The programmes offered are determined by the Superintendent to meet the special needs of his area within the general framework of required services determined by the government. The Superintendent is responsible to the civil service, not to a Board, as is usual in North America or England. The building is modern, and well equipped with a Chest X-ray apparatus and the equipment for dental inspection. A dental officer attends twice a month, and inspection is directed to pregnant and nursing mothers and children: even so the numbers requiring services necessarily leads to a low quality service. Three physicians and eight nurses are full-time employees; with public health inspectors, laboratory personnel, stenographers and clerks, a staff of 50 is employed.

The main programme offered by the Health Centres cover:—

Environmental sanitation, housing, water service, sewage and garbage disposal.

Nutritional education and food sanitation.

Maternity and child health.

Dental hygiene.

Communicable disease control, including tuberculosis and venereal diseases.

Health education.

Eugenic protection.

In the control of communicable disease treatment for venereal disease is offered, while physician examination and X-ray is made in the diagnosis of tuberculosis. Persons requiring hospital treatment are transferred for care to the appropriate special hospital. The chief prophylactic immunisations offered to children comprise smallpox inocculation, diphtheria, typhoid, para-typhoid, pertussis, and polio injections.

The public health nurses visit homes and fill a medical social service role, as well as contact tracing.

Meat inspection, rabies control, milk inspection are among the duties of public health inspectors.

Eugenic protection embraces genetic counselling, abortions, and family planning which is well developed. The birth rate has been reduced to 18.6 per 1,000 population per year.

Mental health counselling and work associated with admission and discharge from mental hospitals is a Health Centre duty. The Japanese aim to provide mental hospital facilities on a ratio of 21 beds per 10,000 but this has so far not been achieved.

The system of medical care delivery in Japan is highly organised and sophisticated, the facilities are comparable but generally inferior to similar structures in North America or England. The Health industry appears both under-capitalised and with too small annual revenue to provide high quality care. When consideration is given to the parameters of quality medical care the physician-population ratio is low, the case load is heavy, and the capital employed per patient treated is low.

Acknowledgments

My thanks are due to Mr. Shimazu, Chief, Hospital Administration Division, Bureau of Public Health, who arranged my visit to the Toshima Hospital and Takinokawa Health Centre; to Dr. Sato, Superintendent, and Drs. Nakajima and Muroga of the Tokyo Toshima Hospital, who answered many questions; and to Dr. Hongo, Superintendent of Takinokawa Health Centre, Tokyo for his information.

Dr. Aikawa, of Odawara, and his dentist wife, generously displayed their health facilities and provided much information.

My able interpreters, Mr. Matsuba and Mr. Yoshikawa, made this project possible, and I am grateful to Mr. Longmuir of the Canadian Embassy, Tokyo, for his introductions.

NURSING SECTION

NON-NURSING DUTIES

One of the most frequently debated subjects today is the somewhat controversial one of non-nursing duties. This affords much food for thought, and inevitably one major question arises. What exactly is a non-nursing duty?

The answer to this would appear at first hand to be quite straightforward. Deeper thought, however, causes one to think that the situation is decidedly more complex than at first is apparent. Basically, when is a nursing duty a non-nursing duty?

One could commence the argument by stating that ward cleaning should not be regarded as the work of the nursing staff. However, although the physical act of cleaning may not be the task of the nurses, the responsibility for ensuring that this is completed efficiently falls squarely upon the shoulders of the ward Sister. If she does not supervise this, then she is neglecting her duty towards her patients. Despite armies of Domestic Supervisors it is the Nursing Staff who in the end must satisfy themselves that the work is carried out to a standard which ensures the safety of the patients.

In another vein, nurses appear to be remarkably adept at becoming afflicted by total deafness when the telephone bell rings. When questioned, they have been known in certain instances to state that it is not their job, but that of the receptionist to answer the call. How can they justify this, however, if the caller is the House Officer to tell them that there is a patient waiting for urgent admission? It can surely only be regarded as negligence to delay any longer the movement of this sick person to the ward.

Many such tasks have this somewhat ambiguous context. In view of this, no nurse can in all conscience refuse to undertake work which will in the end directly affect the well-being of the patients. Her function is to ensure their safety and speedy recovery. Any task, therefore, which in any way hinges on this, becomes either directly or indirectly within her terms of reference.

The profession, as a whole, must accept that it has responsibilities which cover a very wide range of jobs. It is possible to engage other people to undertake these, but in the end the onus falls upon the nurses. Any, therefore, who wish to argue about who should complete which task are going to find their work increasingly difficult.

It would appear, then, that no duty is entirely non-nursing if it is to be undertaken within the wards. It is impossible to differentiate completely. If a nurse has the welfare of her patients at heart, she will be prepared to undertake any task which directly affects them. If she will not do this willingly then is it not reasonable to suggest that she abandon her chosen profession?

CORRESPONDENCE

Thank You

Miss MacManus thanks the many Guy's friends who have sent her greetings at Christmas. She wishes them all a Happy and Blessed 1971.

Terry Lodge, Terrybawn,
Boffenaun, Ballina, Co. Mayo.

Multiple Choice Questionnaires

SIR,—Mr. Stubbs (Guy's Hospital *Gazette*, 16th January, 1971) has performed a most valuable service in airing some of the students' complaints about M.C.Q's. We agree with many of the points he makes. For instance, we are quite sure that some of the questions in the Clinical Pharmacology tests could be worded in a more professional and unambiguous way, but this is a new technique which we have to learn, and the computer not only provides a comment on the candidate's performance, but also tells us how useful and discriminating each question is. This information is used to improve subsequent tests.

The marking system for the Pharmacology and Clinical Pharmacology multiple choice tests is in fact similar to that in Part 1 M.R.C.P.: if a question is left blank, no marks are awarded; if a scribe is made against the right choice, a mark is gained; if a scribe is made against the wrong choice, a mark is deducted.

It is quite true that the Clinical Pharmacology test is set by the individual teachers who are asked to produce questions relating to their own lectures. In many cases there are no gross differences between the content of the lectures and that of textbooks. After all, the books are written by people like that. Reading the books alone is quite sufficient to do well in the tests.

One of the most important reasons for introducing M.C.Q's. in our courses is to inform the students and staff about student learning. It is our impression that gamesmanship plays a larger role in essay-type questions and vivas than in M.C.Q's.

Yours faithfully,

GORDON REEVES,
ROY SPECTOR.

Department of Pharmacology
and Clinical Pharmacology,
Guy's Hospital Medical School,
London, S.E.1.

A Solution?

SIR,—May I comment on two subjects of interest to Guy's sportsmen which have been discussed recently in the *Gazette*.

Firstly, may I express my congratulations and admiration to the four members of the Guy's Hospital Boat Club on their remarkable performance in successfully completing the 112-mile Oxford to London row. Having once been foolhardy enough to scull the Boston marathon—a mere 31 miles—I can assure all non-rowing readers of the *Gazette* that this accomplishment is quite an outstanding feat of both physical and mental endurance.

Secondly, may I comment on the almost perennial problem of the strength of the fixture list of the Rugby Club. Guy's is not alone among the London Hospitals and Colleges in finding it difficult to maintain teams of a consistently high standard. Possibly, therefore, the time has come when tradition should be reluctantly set aside and a regular, fully representative, United Hospitals or, preferably, London University XV should be fielded each week. Such a team would always contain at least a handful of full internationals, and the other members would undoubtedly be of the calibre of trialists, first class county players or Oxbridge Blues. A full U.H. or U.L. XV would regularly rank with the top half-dozen in the country, and it would be a matter of pride for Guy's, or any other College, to see as many of its own men in that team as possible, just as the Oxbridge Colleges take pride in the number of their Blues.

An apt comparison can be made here between the problems of the Rugby Clubs and the Rowing Clubs of the various London Hospitals and Colleges. Alone no College could turn out a crew of quite top-class calibre, but when, at last, the Colleges provided their best oarsmen for the University squad in the early 1960's, the University Boat Club rapidly became one of the two most powerful in the country and has maintained this consistent standard. U.L. crews have represented Great Britain internationally on several occasions in the last decade and, in the last three years, a Guy's man has been in each of those crews. I am sure such a system applied to Rugby would be a great incentive to Guy's Rugby players, would stop the drift of one or two highly gifted players to more powerful Clubs and would still enable these men to turn out for Guy's in the important Cup matches of the Easter Term.

Guy's R.F.C., being almost certainly the most powerful Club in the University, is in an ideal position to call upon the other Hospitals and Colleges to support a truly representative U.H. or U.L. R.F.C. We may then see Cambridge University, or any other club, suffering an "annual humiliation" at the hands of a team containing its fair share of Guy's men.

Yours faithfully,

D. K. C. COOPER

(Vice-President, Guy's Hospital Boat Club).

Addenbrooke's Hospital,
Hills Road,
Cambridge.

"More, More Ron"

SIR,—Having just seen the limerick "More Ron" in your Christmas number, I feel moved to reply :

"Should nurses unbutton their blouses?"
'Tis a question that clearly arouses
Immoderate lust
At the thought of the bust
From elderly babies in trousers!

Yours faithfully,

P. N. EUMATIC.

Hunt's House,
Guy's Hospital, S.E.1.

SPORT

RUGBY

UNITED HOSPITALS RUGBY CUP

Chislehurst. 2nd Round Guy's v. King's. 19th January.
Result: Won 17—0.

As many will know, Guy's have not been having such a great saeson this year, but with this win, morale has returned to the club. To the normal side, returned Chris Neville (second row) and Charles Thorburn (back row) to the pack, and John Ross (centre) and John Novak to the threes. These players had an enormous effect particularly on the pack, which played not only with renewed spirit, but with the charisma of the old Guy's pack.

The game can be divided into four parts. The game began in rather a half-hearted fashion with the two sides weighing each other up. It became obvious, however, after ten minutes, that King's would be unable to win unless a miracle were to happen. Guy's pack was effectively controlling all the loose, tight and most of the line-out ball. King's were saved repeatedly by a competent full-back.

The usual run of cup match penalties took place, which resulted in Guy's scoring a penalty goal after two fairly difficult shots. Martin Danford, the kicker, still had to contend with a blustery wind, and missed no more than his opposite number. Half-time arrived with Guy's having only three points and yet dominating the forwards' game. It must be admitted many of the old supporters were not too happy at this state of affairs, knowing from past experience how easily cup games are lost with a couple of unfortunate penalties.

Indeed, just after half-time, King's were given a penalty right under Guy's posts; fortunately, the King's kicker missed. It may be commented, the referee was rather whistle happy, awarding penalties to both sides for very dubious infringements. Guy's pack now began to put the pressure on. Charles Thorburn kept on appearing from nowhere and running through the King's defence in a most decisive manner. He was followed by the whole pack, which is quite strange to Guy's this season. From such beautiful phase play, Carter Croft (scrum half) toppled over the King's line for a well-earned try.

King's resorted to the standard cup tactic of kicking a high ball up the field. This, with some outstanding errors in the Guy's backs, gave King's a few chances. However, Martin Danford (full-back) performed well to keep Guy's out of trouble.

Guy's pack, however, gradually snuffed out the last flame of King's resistance with three tries. The first by John Novak, the second by Mike Forbes (back-row) was disallowed after a magnificent forward "rush', and the last by Bob Burt (second-row), who took three King's players over with him. This last try was converted, and also another penalty goal was scored.

A comment on the whole match was that the forwards really got going by the end of the game, but the threes have some way to go yet. Indeed, poor handling could have lost the game. John Novak did not perform too impressively, although John Ross worked hard at centre. The tackling by Guy's was very good, and to be fair, the wet, greasy ball did not suit a fancy three-quarters game. There is a very good chance this year to win the elusive Hospitals Cup. Let us hope it comes our way.

T. HIGENBOTTAM.

COLTS 1970/71

The continuous lack of new blood into our sports clubs has been felt this year by the Rugby Club. In past years some 40-50 freshers have attended a trial, but this year only 25 players were seen. It seems a great pity that the oldest rugby club has, on occasion, found itself scrambling to raise a 2nd and 3rd XV side.

Some of the freshers this year made the 1st and 2nd XV's immediately, and for the rest a Colts XV was established to play the matches arranged for the 3rd XV. The main function of this side is to provide players for the 1st and 2nd XV's in subsequent seasons. Up to now the side has been very successful and though, on occasions, it has been strengthened by more experienced players, by and large it has been a team composed of freshers. Results, too, have been promising and some very hard games have been played. Hard-fought successes have been those games played against Sutton 3rd, Old Blues 2nd and Streatham and Croydon Colts 1st XV's, whilst the Law Society 1st XV and Rochester Ex-1st XV proved too easy opposition. Close games have also been played against London Irish 3rd XV and Metropolitan Police XV, which lost by narrow margins.

Of the team it is evident that seven or eight players will one day soon find themselves playing for the 1st or 2nd XV. However, their interest in the club must not be lost as has happened to past fresher players. Dr. Peter Swift is providing much impetus to the side by regularly taking a Wednesday afternoon training session and by making appearances in occasional games, in spite of his heavy schedule in the hospital. However, unfortunately not all the team has taken full advantage of these training sessions but in future, with the Junior Cup upon us, it is hoped that more will attend as many have a chance of appearing.

Team from : A. Mellor, R. Dent, G. Earnshaw, B. Flood, G. Barker, D. Norfolk, M. Turtle, D. McPherson, Dr. P. Swift, G. Marcus (capt.), R. Cording, D. McMillan, S. Killick, R. Bilous, C. Kinchin, A. Helyyar, J. Lamberty, J. Mahood, M. Griffiths, M. Portelli, D. Campbell.

G.B.M.

SOCCER

HOSPITALS LEAGUE

1st XI v. ST. MARY'S HOSPITAL

Played at H.O.P. on 20th January.
Result: Won 1—0.

This was a keenly fought game between two closely matched sides. Guy's were somewhat lethargic getting into their stride, but Captain Edwards, fresh from service behind the bar, was soon exhorting his team to greater efforts. With the defences on top, goalmouth incidents were rare, but Guy's almost opened the scoring when the Mary's goalkeeper failed to hold a fierce shot from Harradine. Just before half-time, Holliday shot narrowly over the bar, after Winter had seized on a defensive error, but the goal-less draw at half-time was a fair reflection of play considering the lack of clear chances.

Despite the heavy conditions, Guy's continued to press forward and the mid-field trio of Godman, McConnell and Winter began to find gaps in the Mary's defence. With less than 20 minutes to go, Guy's at last opened the scoring when Winter backheaded Godman's long throw for Holliday to score from close range. Immediately afterwards, only a fine save by the Mary's goalkeeper prevented Holliday from increasing the score. Guy's, however, were unable to find the net again although McConnell shot wide from a good position in the closing minutes and the game faded rather tamely in the midfield stalemate that had prevailed throughout.

HOCKEY CLUB

GUY'S 1st XI v. WOKING

Saturday, 9th January. Home. Drew 2—2.

With Christmas pudding and New Year's drink still to be flushed through the system, a fast, stamina-draining game was not to be expected. This was, however, a reasonable performance for the first game of the second half of the season. The most noticeable failing was the lack of co-ordination between the halves and the forwards and between the forwards themselves. This is perhaps accounted for by the refusal of most players to make space for themselves when they are not actually in possession of the ball.

For most of the first half, Guy's were pressing hard against the Woking defence and it was only the failure to make that one extra constructive pass which prevented the ball ending up in the net. In the last few minutes an unfortunate combination of events led to Woking scoring a goal when it seemed least likely. For once the opposition's defence managed to clear the ball through the Guy's ring of forwards who were stopping it well. The ball ran free up the centre of the pitch to three forwards. It only required a complete misunderstanding amongst the defenders to leave Bob Clarke, in goal, no chance at all. Thus Guy's changed ends one goal down having almost scored on at least two occasions.

The second half began in much the same vein as the first had ended, and again Woking scored against the run of play. This time, after a short corner, the ball rolled free to one of their forwards on the edge of the circle. David Crafts, on the goal line, did well to get his stick to the shot but the ball rebounded upwards, glancing his shoulder, which prevented a goal. A penalty flick was correctly awarded and duly converted.

Things looked gloomy for Guy's at this stage, but two-thirds of the way through the half the unbelievable happened. Bill Brownlee, deputising well at centre-forward, was presented with the ball from a rebound off the goal-keeper: he took his time and made no mistake. Then a few minutes later Bob Fell found himself unmarked in the circle with the ball on the end of his stick: a very good shot saw the ball safely into the goal.

With the score at two all, the Guy's team breathed a sigh of relief and began to unwind : the holiday indulgence was beginning to be felt. The final result was a draw, which most people seemed glad to have salvaged from being 0—2 down. Had there been a little more combination all round, the result might have been a convincing win. We now look forward to a change from "obstacle-golf" to a few games on the plains of Cobham !

P.T.C.

2nd XI HOCKEY REPORT

At a time of the year when players and morale tend to be low (coinciding with the weather and approaching exams), it is pleasant to be able to write in praiseworthy fashion about the 2nd XI. Although positive results continue to elude us, the team is playing with more fight and resolution and on Saturday, against Romford, we really looked like scoring goals and a lot of pressure was taken off the defence. The intelligent play of Shutes must be mentioned, who, in his two games, developed an immediate understanding with Velacott against Woking and looks like forming a useful partnership with Barry Jones on the left wing. Several players now have first team experience and it is hoped that this will rub off onto the rest of the side in terms of ideas and enthusiasm. Fitness is always a problem with the 2nd XI, but one hopes that with Sunday matches and the approach of the Cup, the lack of fitness will be less evident. The cup sides are by no means settled and with high prospects of success we are hoping for plenty of competition for places and support for the side.

Finally, I would like to appeal for individuals to umpire for us on occasions. There are many such who have played for Guy's and we hope one or two will offer to give up an afternoon occasionally.

B.M.

HOSPITAL INFORMATION

THE BOARD OF GOVERNORS OF GUY'S HOSPITAL invites applications from registered Dental Practitioners for the appointment of **Registrar/Demonstrator in Oral Surgery and Dental Casualty** (whole-time) to commence on 15th March, or as soon as possible thereafter, until 30th September, 1971. The post will be subject to the terms and conditions of service of Hospital, Medical and Dental Staff in the National Health Service. Applications to the Superintendent, Guy's Hospital, S.E.1, Tel. No. 01-407 7600 (Extension 318) not later than **12th February.**

GUY'S HOSPITAL BOARD OF GOVERNORS.

Applications are invited for the post of **Senior Registrar in Child Psychiatry** with duties to commence as soon as possible until 30th September, 1971. Forms of application are obtainable from and should be returned to the Superintendent, Guy's Hospital, not later than **5th February, 1971.**

Applications are invited for the post of **Senior House Officer in Gynaecology** at St. Olave's Hospital of the Guy's Board of Governors for a period of six months in the first instance, commencing 1st March, 1971. Applications with the names of two referees or enclosing two recent testimonials, should reach the Superintendent, Guy's Hospital, London, S.E.1, not later than **5th February, 1971.**

GUY'S HOSPITAL

Applications are invited for the appointment of **Registrar in Anaesthetics** to the Guy's Group of Hospitals for the period 1st February to 30th September, 1971. Apply immediately to the Superintendent, Guy's Hospital, naming two referees.

HOUSE APPOINTMENTS—1st March, 1971.

In the event of the postal strike continuing, will applicants for house appointments commencing 1st March, 1971, contact Mrs. Webster, in the Counting House (Extension 318) on 3rd February, 1971, to obtain the results of their applications.

PERSONAL

Dental Nurse required private practice Harley Street area. No Sats. Excellent salary and conditions. Congenial atmosphere. Holiday arrangements honoured. Telephone: 01-935 3231

Bath: Associate/Assistant required end of March, to join three Guy's men in well-equipped practice. Low seated, high gross from mainly conservative work. Private and N.H.S. Box No. 2/1.

STUDENTS' CLUB

An Extraordinary General Meeting of the Students' Club will be held in the Ballroom on the First Floor of the Students' Club, on Friday, 1st February, 1971, at 1 p.m., to consider a proposal that the Students' Club should join the Junior Hospital Doctors' Association.

CHANGES OF ADDRESS

Mr. and Mrs. Jonathan Pedre, 13, Limetree Close, Grovelands Park, Grove, Wantage, Berks.

J. Snarey Wright, Esq., Flat 3, 25, Albany Villas, Hove, BN3 2RT.

Mr. Paul J. Wright, 9, Devonshire Place, London, W1N 1PB.

Dr. and Mrs. A. P. O. Stewart, 2, Higham Road, Huntroyde, Nr. Burnley, Lancs. Tel.: Padiham 72389.

BIRTHS

BELL.—On 24th December, 1970. At the Louise Margaret Hospital, Aldershot, to Elizabeth (née Murray) and Capt. Duncal Bell, R.A.E.C., a daughter, Rachel Elizabeth.

PADFIELD.—On 21st November, 1970, at the Kingston General Hospital, Kingston, Ontario, to Christopher and Veronica Padfield, a son, Michael Christopher.

DEATH

MILLARD.—On 16th January, 1971, Miss Augusta Millard, aged 95 years. Trained Guy's, 1904.

We would like to remind our readers that all copy for inclusion in the "Gazette" must be received eight days before publication date.

Copy may be sent to us c/o The Front Lodge, Guy's Hospital or left in the "Gazette" pigeon-hole in the East Wing.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, please indicate whether or not this should be published.

Personal notices one shilling per word (pre-paid) (minimum £1. 1s. 0d.).

Non-subscribers will pay £1. 1s. 0d. (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

EDITORS N. D. S. BAX and A. M. TURNER
NEWS EDITORS R. M. DARLING and J. LEWIS
SPORTS CORRESPONDENT T. W. HIGENBOTTAM
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TWO SHILLINGS VOLUME 85 NUMBER 2154

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Introductory Courses

For a nurse, changing wards takes a little adjustment and therefore time before she begins to function as effectively and efficiently as she had previously. Similarly for a student, the first few days on a new firm can be somewhat difficult. There are new contacts to establish, new routines and in some cases new methods of medicine to learn. These all take time. Some firms have adopted the practice of running introductory courses. They are in essence potted teaching in recognition of symptoms and signs with which the student may not be familiar and an assault by a barrage of new words. These courses are popular because they are, in general, found to be helpful. However some, because of their brevity, are only of limited use.

In addition to helping with the academic side of medicine, the introductory courses enable teachers to meet students and vice-versa. If practised more widely this would perhaps stifle the common remark heard after a week or so of the start of a new firm that few members of it have been seen on the ward.

A word that is at present extremely fashionable is "team". Upon starting some appointments the student members of the firm are told they are part of a team. These are the appointments which by their nature necessitate the student involving himself with a particular ward, and contributing to his patient care, albeit in a relatively small way. The appointments where the student does not have a

base and additionally lacks any responsibility for a patient's care, are beset with problems from the outset. Certainly the student does not feel part of a team, but possibly the greatest problem is that an individual student will personally see very little clinical material during the three months.

Even so, many firms might benefit from running a familiarisation course for each new batch of students. This would enable everybody to meet and attempt to overcome any initial problems.

Charity or the State?

Why have a privately organised society for mentally handicapped people or for spastics? It is perhaps inapt to question the reason for the existence of organisations that appear to work efficiently and harmoniously: none of us is going bald-headed with worry because we rely on collecting boxes in pubs for the blind, the deaf and goodness knows how many other people in need of our aid. But at the moment the way we grant money to such people is badly conceived. We have organisations that perform essential tasks in arranging employment and accommodation, sponsoring research, one of the beneficiaries being Guy's Paediatric Research Unit, and, now here is the embarrassment, arranging treatment in the form of physiotherapy and speech therapy for them.

Long needed reform was achieved with the 1970 Act for Chronically Ill and Disabled People, empowering local authorities to provide special work, equipment and housing. But the lack of provision of long-term treatment remained. Not enough doctors refer spastics for physiotherapy that can improve their condition. When they are so referred they are often passed on to the specialist physiotherapists financed by the Spastics Society. That they go to experts is as it should be but these private societies have to expend a great deal of their income every year in financing schemes to raise more money. It is not merely a question of the community not facing its responsibility in providing for the treatment of chronically disabled people, it is more that the societies that do provide such treatment rely upon costly ways of collecting money such as flag days, collection boxes and making films of self-advertisement. Their own football pools bring in a great deal but not enough.

Naturally we must not discourage private individual charity: dropping a few coppers into a collecting box is the most personal form of charity many of us achieve, but the treatment of chronically sick people financed this way is both inefficient and unmindful of proper responsibility.

GUY'S DIARY

FEBRUARY

15	M	1.00	Clinical Lecture. Mr. ELLIS. "Recent Advances in Transplantation."
16	Tu	1.00	Clinical Lecture. Mr. HUDSON. "Toxic effects on the eye."
18	Th	1.00	Clinical Lecture. Dr. MACKEITH. "Crying and Sleeping Problems in Children."
19	F	1.00	Clinical Lecture. Dr. JOHN WALL, of the Medical Defence Union. "Legal Hazards for the Doctor."
		1.00	Staff Round. "Metabolic Cardiac Arrest. Mr. F. G. ELLIS. Chairman: Professor J. N. HUNT, Clinical Lecture Theatre, New Guy's House.
		2.15	Combined Round. Dr. McARDLE. "Neurological Cases."
22	M	1.00	Clinical Lecture. Dr. DEUCHAR. "Non-invasive Techniques in Cardiology, with Demonstrations to be presented by Drs. Gosling, Shelley and Wharton."
23	Tu	1.00	Clinical Lecture. Dr. MANN. "Are symptoms Really Necessary?"
25	Th	1.00	Clinical Lecture. Professor HUNT. "Tests of Gastric Function."
26	F	1.00	Clinical Lecture. Dr. HYAMS.
		2.15	Combined Round. Mr. HENRY. "Tuberculous Gluteal Bursitis."

RESIDENTS' PLAY RECORDS

Records of the 1971 Residents' Play, "Waiting for McAddle", or "Oh! What a Lovely Ward", will be available shortly at an approximate price of £1.50 (30s.). Final price dependent on demand, so order now from :— Richard Dunnill, East Wing; or Trevor Thomas, Dept. of Haematology.

SOUTH WALES AND MONMOUTHSHIRE GUY'S HOSPITAL SOCIETY

The 20th Annual Meeting and Dinner of the Society will be held in Cardiff, at the Park Hotel, on Saturday, 13th March, 1971, the evening of the Wales v. Ireland Rugby Union International match at the Cardiff Arms Park. The meeting is at 7.0 p.m. for 7.45 dinner. Dress informal, and all Guy's men and women visiting Cardiff will be welcome. Those who intend coming to the dinner, particularly from outside the Cardiff and Wales area, are advised to contact the Honorary Secretaries at an early date as there may be limited accommodation. The cost of the dinner is £2.75. It is hoped to welcome a strong present Guy's contingent.

Woodlands,
Cwnt-yr-ala Road,
Cardiff CF5 5QS.
Tel: 0222 591469.

D. Glyn H. Davies,
H. Anthony Thomas,
Joint Hon. Secretaries.

NEWS IN BRIEF

Guy's Tower

Since the last time an article on the new Tower appeared in the *Gazette* was March, 1969, it might be useful to recapitulate some salient facts for those not familiar with the development.

The Tower is the second stage of the Hospital's long-term development and is due for completion towards the end of 1973. When completed it will bring together under one roof a number of departments which at the moment are dispersed and provide them with more adequate accommodation in which to function.

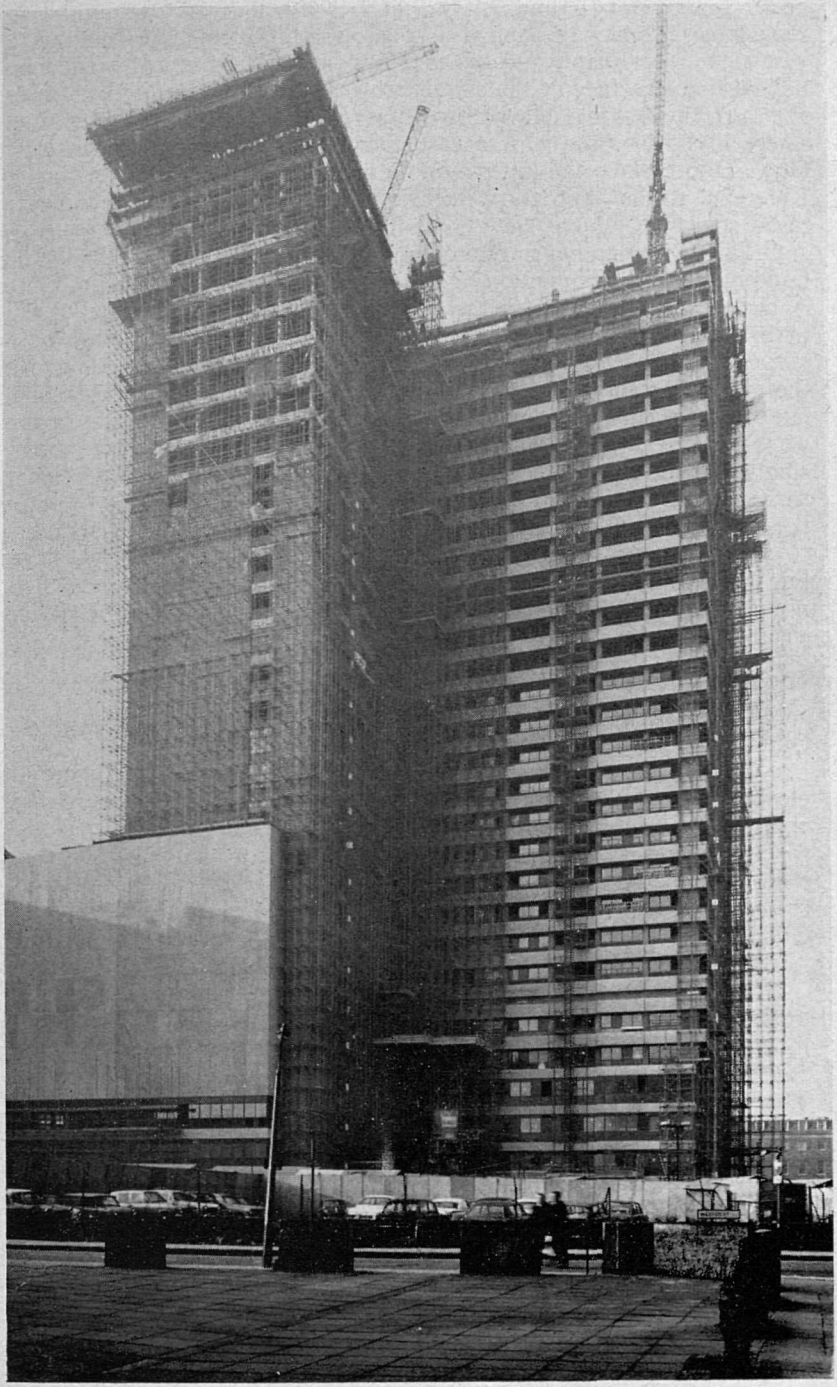
The larger of the two towers contains the major part of the working accommodation and starting from the ground floor will contain a new ante-natal clinic, three new theatres together with a greatly expanded clinical microscopy department, changing accommodation and ancillary facilities, e.g., recovery areas, etc., a new surgical intensive treatment area, a new diagnostic X-ray department and cardiac investigations theatre suite and new clinical pathology laboratories. All these areas will be on the lower floors which are easily identified from without the building because they have no balconies. This will facilitate their expansion at the next stage of development if this is considered to be necessary.

Above the fifth floor and in ascending order will be:—

Floors 7—8	Paediatric Research.
Floors 9—12	Paediatric wards, including a burns unit, isolation unit, metabolic unit and special care baby unit.
Floors 13—16	Obstetric floors including eight first- and eight second-stage delivery rooms and a G.P. Maternity unit.
Floors 17—18	General research and medical photographic and illustration departments.
Floors 20—28	Dental School and Department with an increase to 219 chairs and units.
Floors 29—30	Lecture theatre.

It should also be mentioned that on the lower ground floor will be a new twin instrument electron microscope department, and a kitchen and cafeteria for non-residential staff.

The building is completely air-conditioned and the floors missing from the above sequence are the plant floors which will contain the extensive plant necessary both for the air-conditioning and for providing the multitude of piped services necessary to a modern hospital. At the corner of Sparricks Row and Great Maze Pond is the new



Guy's Tower.

boiler house to be commissioned in December of this year, and to replace completely the existing boiler plant. It will also contain a new incinerator plant, and the six flues from all these are carried up behind the west face of the smaller tower. Also in the smaller tower are thirteen lifts, five of which will serve the dental floors exclusively. These lifts will also help to ease the distribution problems in New Guy's House since the latter's floors are all connected to the Tower. Reference to the photograph will show this "link", being the concrete faced structure joining New Guy's House and the Tower.

The accompanying photograph also shows the shell of the building nearing completion and was taken in early December, 1970. A close examination of the scaffolding at the top of the face of the main tower closest to the viewer will reveal some scaffolders, whose size gives a good impression of the immense height of the building. In the angle formed by the two towers is the liquid cement hoist which has been ceaselessly in operation since the superstructure first began to take shape over two years ago. At the top of the face of the smaller tower can be seen the very complicated scaffolding necessary to construct the lecture theatre overhang, and a fuller account of these features will be given in the next contribution to this series.

"Topping-out" can be anticipated for the summer of this year, but the fitting out process will take a long time to complete and it is not at the present time envisaged that any part of the main building will be ready for occupation before the end of 1974.

The Guild of Ex-patients and Friends of Guy's Hospital

£8,178 was the total of subscriptions and donations given to the Guild last year. This is an increase of over £1,000 on 1969.

Among the gifts provided by the Guild for the Hospital were an electric page turner for a paralysed patient, ninety Parker-Knoll chairs, a piano and a table-tennis set for the York Clinic, furnishings for the Mortuary Chapel and television sets for the Nurses' sitting room and the new sitting room for mothers in the Evelina Hospital. Every patient in hospital on Christmas Day received a gift from the Guild. £100 went to help Radio Guy's and over £3,000 towards research equipment for the Medical and Dental Schools.

The Guy's Hospital Ladies' Association, another charitable organisation at Guy's, and the Guild may well soon amalgamate and form one new body, which will be called Friends of Guy's Hospital.

The Guild's annual general meeting will be held in the Physiology Theatre, Medical School, Guy's Hospital, on Wednesday, 28th April, at 6 p.m. All are welcome.

South Wales and Monmouthshire Guy's Hospital Society

A notice appears in this issue about the Society's 20th Annual Meeting and Dinner. During the dinner a cheque for £300, representing the proceeds of the T. J. H. Evans Memorial Appeal Fund, will be presented to a member of the Medical and Dental School Council. It is intended that this gift will be used by the Council as a basis of a biennial prize to Guy's medical and dental students.

Articles

Main articles for the *Gazette* are obtained primarily from past and present members of Guy's Hospital. If any of you have particular experiences or interests about which you would like to, or indeed may have already written an article, we would be pleased to receive it with a view to publication.

Apology

In the last issue's News in Brief we reported that Miss Catherine Daughtry was leaving Guy's to marry Professor Neill. We mispelt her name on this occasion and for this we apologise.

ANNUAL CLINICAL MEETING, 6th MARCH, 1971

(ABBREVIATED PROGRAMME)

MORNING SESSION (10 a.m.—12 noon)

ANATOMY LECTURE THEATRE, MEDICAL SCHOOL

11.45 a.m. Lecture: My Year in Iran. Professor W. E. Herbert.

THEATRES Nos. 1 and 3 (FIRST FLOOR, NEW GUY'S HOUSE)

Operations commencing at 10.00 a.m.

GENERAL ANAESTHETIC EXTRACTION ROOM (FIRST FLOOR, OUT-PATIENT DEPARTMENT)

10.00 a.m. Removal of Lower Third Molars. Mr. P. M. Driscoll. Anaesthetist: Dr. R. G. F. L. Seed.

There will be DEMONSTRATIONS AND DISPLAYS in all the Departments of the School.

AFTERNOON SESSION (2 p.m.—4 p.m.)

DENTAL LECTURE THEATRE

2.15 p.m. Lecture: Cases you have sent. Professor R. A. Cawson.

There will be DEMONSTRATIONS AND DISPLAYS in all the Departments of the School.

TEA will be served in the Cafeteria, East Wing, Guy's House, at 3.30 p.m. Programmes giving full details will be available at the Clinical Meeting.

NEWFOUNDLAND — AN OUTLINE

By N. R. T. Pashley

The first special appointment gives that opportunity to be called doctor in some remote part of the world. The decision to go to Canada was based on finance and an interest in North America.

St. John's, Newfoundland, was an accidental application and offered the following: air fare paid in one direction (Air Canada), free board and lodging, £60 per month tax free, and a four-month minimum stay. Second form geography supplied a barren glaciated granite island with thousands of lakes, few trees (the Grand Banks are where the soil went), cod fishing off the Banks, mineral wealth, fishing communities and numerous banachois (fresh water lakes behind a sea-swept bank of shingle, which are unique here and in Scandinavia).

What follows is some outline of Newfoundland:

> "The island of Newfoundland has been considered as a great ship moored near the Banks during the fishing season for the convenience of English fishermen".
>
> *William Knox*, House of Commons, 1793.

Newfoundland is moored on the easternmost coast of Canada. A vast triangle with a S.E. triangular peninsula, the Avalon, reaching into the Labrador current. Its tip barely touches the Southern reaches of Labrador. A vertical west coast, 300 miles long, with fjord-like architecture and deep pine forest clothing the Long Range and Annieopsquotch Mountains, stretches to a horizontal southern limit 200 miles long. The west coast facing the maritime Provinces of Canada 300 miles away across the Gulf of St. Lawrence, makes good use of its trees in the Bowater pulp and paper complexes centred on Corner Brook and Stephenville, lying midway along the west coast.

Streaming in a thin ribbon the width of St. Thomas' Street (and two-way traffic the same, too!), the Trans-Canada Highway ends at the south-west tip of the island in Port-au-Basque, draining from its source, St. John's the capital, 565 miles away on the Avalon. It comprises all the surfaced road in the island and the inter-communication of small hamlets and the all-important bays. Slowly the picturesquely named fishing villages are forging pathways through the rock and musk swamp toward this life-line. The Bays (and all Newfoundlanders are baymen at heart), Notre Dame, Bonavista, Fortune, Placentia, Bay of Islands, Conception are a few that have been connected. Thus Twillingate on New World Island, Come-by-Chance, Bale Verte, Heart's Content, Argentia, Bay Bulls, Ponch Cove and Grand Bank all siphon to the asphalt. However, the south coast retains its remoteness, Burgeo, Bay d'Espoir, Belleoram, Harbour Breton are still served by boat.

St. John's, the capital and easternmost town in N. America, supporting 110,000 people, is the focus of the outposts. "The biggest outpost of them all" possesses a fine boot-shaped natural harbour guarded by the towering cliffs of the Narrows and Signal Hill Fort above. Here in the 1600's a look-out for the French, after their colonisation of Placentia in 1662, was formed to protect the St. John's based cod-fishing industry. Later a huge chain was placed across the Narrows ; Chain Rock survives today in the Channel. In 1790 the look-out was fortified, and in 1901 a return to signalling was made when on 12th December Marconi's letter "S" was received by wireless from Poldhu, Cornwall. St. John's has other important communication history, the site of the children's hospital today in Pleasantville, across lake Quidi Vidi on the outskirts of the town, is the scene of preparation of many of the first successful (and otherwise) transatlantic aviators.

Here is the site of Premier Joey Smallwood's dream, when Newfoundland, up until then a British colony, became confederated in 1949. Smallwood has been in command ever since and many people in the outposts think he personally signs their weekly pay-cheque. He built for himself and his Government, at the back of the city, an impressive Confederation Building, with his office on top overlooking all St. John's and the Narrows. A clever, shrewd politician, he realises Newfoundland's wealth lies in minerals (including oil), fisheries, and perhaps most of all, the university. He realises Newfoundland is a unique place particularly sociologically and he is a conservationist. He realises Newfoundland needs a lot of outside support, too.

Confederation itself changed the Newfoundlander little. He is a Newfoundlander first, British second, and a Canadian third (the Union Jack is often flown higher than the maple leaf). He frankly despises the French Canadians because of their separationist views. It is they that have forced Canada and Newfoundland to be officially bilingual.

The university is Newfoundland's great hope. By 1975 a 12,000 population campus will exist. Mainland students are quick to realise the advantages of a totally new format and a good deal of interest from both sides of the Atlantic is being shown, particularly in the medical faculty. The attraction is freedom in the form of unlimited finance (Federal guarantee), beside an exciting new programme. The President and Vice-Chancellor is Lord Taylor of Harlow, a physician himself, who suffers from infectious enthusiasm.

Inevitably the influx of new talent and radical thought will affect Newfoundland. There is a demand for cultural arts with increasing sophistication. It is to be hoped that the good points of life in a simple, if struggling Newfoundland, are not lost for the sake of gaining new ones.

Of Men and Fish

The Beothuk Indians, a separate ethnic group from the Eskimo of Labrador, were the first Newfoundlanders, and were lost to history when their sole survivor, an elderly woman, died in 1810.

Much of the outpost population came from south-west England and Ireland, a fact reflected in the gentle burr of Irish in the Newfoundland accent, devout Catholicism in many areas, and a "loikin' " for beer chased by an infamous rum named "Screech".

Scattered place names such as Spanish Room, Frenchmen's Head and Portugal Cove hint at other ancestry. Each year the connection is renewed with Spain and Portugal when St. John's is host to the White Fleet, a fishing fleet of sail-rigged schooners which arrive in April, leaving in November. They retain their method of fishing from 12-foot dorys, each boat being picked up with drift nets at the end of the day by its mother vessel. Many of the dorys are now outboard powered. Appropriately the seamen are always tatooed, not with the lurid details of "mother" surrounded by bluebirds but with the number of their boat, and usually this is in the axilla. Identification after prolonged immersion in ice water and exposure to the codfish can be a problem.

The Newfoundlander jigs his cod from a long liner (35-footer). Jigging uses a line wound round a wooden square, a steel wire leader, and a large minnow-shaped line with multiple hooks. When it hits the bottom he jigs it—jerking it back and forth (only 2% of the fish caught are now taken this way). Most Newfoundland fishermen cannot swim nor have any desire to learn. If you fall in out of reach of the boat, then you so rapidly become hypothermic that drowning is inevitable. The weather is spoken of by the small cemeteries with neatly tended graves of "souls lost in the storm".

The fog lends a mysterious air to the coast, rolling quickly in great walls. The Labrador current meets the Gulf Stream off St. John's and the fog here is rarely still for long. It is clean fog though which soon soaks one and leaves the dogberry trees dripping. In winter it freezes and hoares everything. Surprisingly, St. John's lies on a latitude the same as Vienna and Munich, the winter temperature rarely going below 15° F. (minus 7° C.). Summers are British!

I believe in . . .

The twin towers of the Catholic Basilica dominate the waterfront area of St. John's. Just below lies the stone Anglican Cathedral. Thus has been life, particularly in the outposts the church binding the community together. Where determined people have struggled to survive in the past, their hopes have always been in the church. Until 1969 the schools were denominational—they still retain some of this as the "Micks" are rather separatists. Two of the general hospitals are still controlled by denominational boards. There is no feeling of forced religion here—just the open honest goodness of people which is the salient quality of the Newfoundlander.

The Anglican church stands at a point nearly 55 yards behind the Church of England, but it would be an error to think the Newfoundlander primitive. The rest of the world thinks they are, and with Canadianism, they are becoming sensitive to this. Sophistication of thought is slow to arrive here.

> "The purity of the air of Newfoundland is, without doubt, due to the fact that the people of the outposts never open their windows". *J. G. Millais,* 1907.

The communities are entirely coastal, but even so on the Avalon Peninsula there is in excess of 1,000 square miles of unpopulated area designated "wilderness". Until five years ago more than 70% of the outposts had no sanitation or running water, and with total winter isolation, the birth rate in September to October is astronomical. In some areas inter-marriage is predominant, and incest and in-breeding not uncommon. (The incidence of congenital malformations and mental retardation is extremely high). The average family includes five to eight children (the gravida 23 delivered of her 18th living child was an exception—no twins incidentally). Work is not plentiful, and with free medicine and welfare, the sickness rate has started to become a sizeable part of a G.P.'s practice. The poverty is relative, as almost every house has a TV on instalment and a car, and sometimes the remains of another parked next to it.

Most outpost men have a passion for hunting and fishing, which is allowed anywhere provided you have a game licence. Small arsenals of weapons and fishing poles abound. Road hockey is the sport of the black gravel road here being played with a tennis ball and ice hockey stick. The outposts are a link with history and humanity. Here, in the land of cod tongues, fish and brews, flipper pie, and partridge berries compassion for the hard life people lead is not difficult to find.

Medical Care

The priest was the mainstay of medical care. If he could not help, he could pray; commonly he was skilled and accomplished as an obstetrician, widely versed in "hatching, matching, and dispatching". The G.P. was an overworked rarity with perhaps 20,000 patients scattered on a long coastline. He charged what they could afford, often nothing. His standing in the community was evidenced in the way people have reacted to the movement of their G.P.'s to St. John's (with the coming of the Medicare Plan (M.C.P.) in 1969) by following them. Such is their implicit trust that patients would rather drive for four hours to the capital than entrust their care to someone new, modern in outlook and unpractised in their community. This gives some idea of the common bond between doctor and patient.

The clergy in the past, and now the cottage hospital G.P. is helped by the local "midwife", a rotund, robust personality whose qualifications are those of any mother of seven or nine grown children. These women are very reliable on physical signs and symptoms, and often good diagnosis, although it is usually phrased in more colloquial medical terms.

Private medicine exists in St. John's as in any city. The M.C.P. is a provincial scheme, in line with those of the other Canadian provinces, which undertakes to pay for the medical treatment of patients, excluding their outpatient drugs. The Government subsidises the doctor per capita and at a grade rate per type of treatment. Welfare cases get free drugs. It is the poorer employed who suffer, as they are often given a prescription for drugs they cannot afford. The difficulty presents with patients very adequately diagnosed, for whom one can do little because they refuse to fill out the prescription

due to the charge. This sort of social problem exists also outside medicine, and small wonder the outpost Newfoundlander opts for welfare.

Doctors here, with lawyers, are no exception to the Canadian rule of being the highest paid professions. With the onset of "free" medicine, the work load per doctor has slowly increased, and the per capita subsidy remained the same.

In St. John's, three general hospitals, children's and mental hospitals and a TB sanatorium provide good cover for the whole province. The General Hospital, St. John's, with 450 beds, is the largest, although integration into a teaching programme with the medical faculty (founded 1967) and the Campus of Memorial University of Newfoundland (founded on its new site in 1961) is taking place in all. A 500-bed University hospital with the 1,000 acre complex of the Campus is in the architectural stage; and the faculty now has 23 2nd year and 32 1st year students installed within the eight million dollars Natural Science Building. Three major divisions are integrated in teaching; all study clinical science and community medicine.

The Cottage Hospitals under Government supervision and in the north under the Grenfell Association are unique. Each hospital serves an area extending in radius up to 100 miles, and has 42 beds divided equally into obstetric, mixed medical/surgical, and paediatrics. These are cared for by four G.P.'s, one of whom has some surgical experience, the others sharing anaesthetic duties. Each has his own patients run from a small surgery below the wards in addition to helping run the various clinics. A small operating theatre, delivery room, laboratory and a cold-tube for X-rays mean that the G.P. has a uniquely satisfying and complete participation in patient care. More complex cases are sent into St. John's by car or aeroplane. Doctors are encouraged to join the Cottage Hospital Scheme by this participation and by the pay and allowances ($20,000 p.a., furnished house, car, petrol and food allowances, usually on a two-year contract). The International Grenfell Scheme is similar, but serves the Eskimo communities of Happy Valley and Goose Bay, Labrador. Pack ice in winter extends to the Grenfell's centre in St. Anthony, N. Newfoundland and early spring sees the seal hunt in this area and to north and west.

The Future

"I will work 15 hours a day for Newfoundland.

"I will drag Newfoundland . . . into the 20th century."

Premier Joseph R. Smallwood, 1969.

What does the 20th century have for Newfoundland? 30,000 Newfoundlanders left Newfoundland in the seven years up to 1969. Of those remaining, 3,000 are at Churchill Falls, Labrador; 6,000 are school teachers; 14,000 work as Civil Servants.

The population (including Labrador), with 50 per cent below 20 years, is 510,000.

Labrador has great wealth. Churchill Falls is due to produce hydro-electric power of six million horsepower potential and some of the highest quality iron ore is found here (high enough to kill Bell Island, a solid lump of iron ore in Conception Bay which formerly supported 16,000 people and now gives cold shelter to a dwindling 1,500). Much has to be explored and rumours abound. Nature, particularly her climate, keeps most of the truths locked firmly in the soil.

Deep water ports, with the opening of the N.W. passage by the tanker "Manhattan" last winter, are under consideration. Oil and uranium (the latter after 80 cases of carcinoma of the bronchus in one area were traced to radon gas leaking with water into old mines) may provide something of a boom.

A freshwater plant which was given extensive Government assistance has already stirred animosity, and a phosporous plant which successfully poisoned part of Placentia Bay early in 1969 are examples of retrograde development.

The University, it seems, holds a gigantic key, in its research projects in all fields, which could open the door of new prosperity.

It is to be hoped that the old Newfoundland which has weathered many hard winters, can survive a tide of civilisation and the inevitable flotsam left in the ebb.

PAEDIATRIC COURSE FOR GENERAL PRACTITIONERS AND LOCAL AUTHORITY MEDICAL OFFICERS

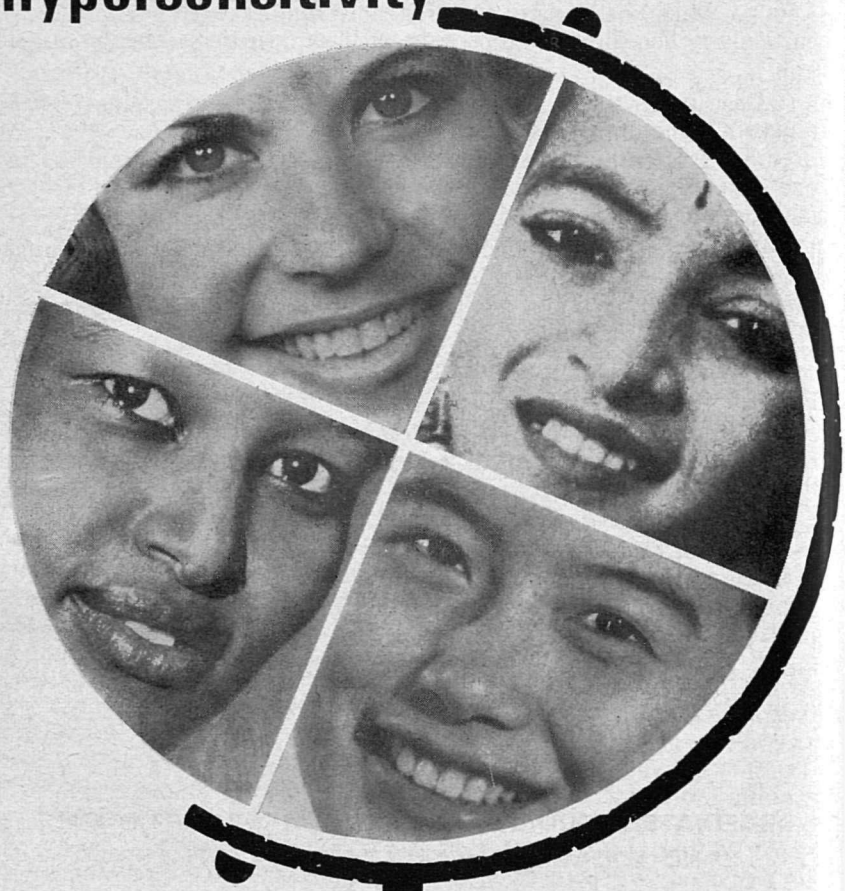
The British Postgraduate Medical Federation will hold a Week-end Course in paediatrics for General Practitioners and Local Authority Medical Officers entitled "Paediatrics". This will take place at the Evelina Hospital on Saturday, 27th February, and Sunday morning, 28th February.

Applications for a place on the Course should be made to the Hospital Secretary, Evelina Children's Hospital, Southwark Bridge Road, London, S.E.1, as soon as possible.

GUY'S HOSPITAL STUDENTS' CLUB

Election of Student Representatives on the Students' Club Council for the year 1971-72. Ballot will be held on **Thursday, 25th February, 1971.**

The answer to oral hypersensitivity



EMOFORM

MEDICATED TOOTHPASTE

Where you diagnose tooth hypersensitivity recommend the regular use of EMOFORM for *effective* relief and *continuing* freedom from discomfort.

Full information from

PHARMACEUTICAL MANUFACTURING COMPANY
(PROPRIETORS: WIGGLESWORTH LTD.)
WESTHOUGHTON, BOLTON. BL5 3SL

EMOFORM is available from all Chemists in 50G. and 100G. tubes.

NURSING SECTION

EXTRA PAY—OR SHORTER HOURS—OR BOTH?

The leaders of the Nursing Profession are currently at an impasse with the management side of the Whitley Council as the annual battle for a salary increase gets under way.

Despite the fact that most nurses will feel strongly that they should receive a 15 per cent award instead of the 7½ per cent which is being offered, one cannot help but be encouraged by the attitude of the Council regarding the number of working hours.

The request was made for a reduction to a forty-hour week on 1st April, 1970, and a further one a year later to thirty-eight hours. The offer has been made of a forty-hour week in 1972, with no further reduction. This, in fact, would seem to be a much more realistic ideal.

As everyone is aware, recruitment is currently at a low ebb. We cannot at present provide an efficient service by working for forty-two hours a week. How, therefore, is it expected to do so by cutting down on working time? Surely, instead of arguing as to how every-one can do less, it would be more beneficial if our illustrious leaders turned their thoughts to two other subjects.

Firstly, the nurse's salary should be completely reviewed. Why does one earn more to do the same work in a "Salmonised" hospital than in one which has not adopted the scheme? It is true that by 1973 all hospitals must have changed their administration, but why should those that have not as yet done so have to suffer? Why are some hospitals advertising what appear to be posts based on the Salmon administration, and then not remunerating their employees appropriately?

The other financial point is one of overtime. Why pay it at all? Surely if nurses are to be regarded as professional people they should be paid as such. This would allow for the fact that no trained people who have any conscience will leave their ward exactly on time every day. This fact should be appreciated. If it were not for the trained staff remaining on duty for many extra hours, the hospital service would completely disintegrate. Why then are nurses not treated like others working in professions?

The second subject is one of Personnel. It is gradually becoming impossible to administer the wards in view of the increasing lengths of time the nurses are spending away from them. Should not some thought be given to this? Who is going to provide the daily care? It is not surprising that recruitment is so low and wastage so high when young girls see what is actually happening in hospitals. No one wants to be part of a service that gives in many instances such appalling care. Who is to fulfil this task?

Surely the answers to these two questions would be more beneficial in a practical sense than the current trivial arguments over the reduction of two hours working time, which will be impossible to observe even if it is introduced.

CORRESPONDENCE

SIR,—A year or two ago the Medical School Secretary had the old and unsightly warning indicators replaced outside lecture theatres. The cost was surprisingly high, but despite their greatly improved appearance, the new indicators appear to have little effect. Almost every lecturer, particularly in the large Anatomy Theatre, is embarrassed by loud conversations, often plainly unnecessary, in the corridors outside the theatre. To ensure that lecturers and student audiences are spared such rude interruptions, only moderate powers of observation and a little social consideration are required. Since both qualities are at a premium in medicine, it seems particularly unworthy that so many students and others completely disregard the indicators—a thoughtlessly anti-social attitude to their own brethren, straining to hear lecturers often of low audibility, in an acoustically abhorrent theatre, against the hubbub of chatter outside the theatre doors. It is indeed surprising how many people, including members of staff, rather disagreeably disturb the work of their own fellows in this medical school by their thoughtlessly noisy behaviour in the public corridors, in any case perfectly constructed to ensure maximum reverberation. Anything above reasonably low-pitched conversation inevitably penetrates into the rooms opening from these corridors. I am sure that few of us really wish to seem to be so unthoughtful of others.

Yours sincerely,

ROGER WARWICK.

Anatomy Department,
Guy's Hospital Medical School,
London Bridge, S.E.1.

Multiple Choice Questioned?

SIR,—I would like to answer Mr. Stubbs' anguished letter on the subject of "M.C.Q.s"—not to defend the sort of questionnaire to which he appears to have been subjected, but in defence of the technique when properly used. I urge him and other students not to reject a technique which, when properly constructed and used, is more accurate, valid and fair to students than any other at our disposal. To reject the technique on the basis of their experience of imperfect uses of it would be sad.

Regarding his first, semantic, point: urging the avoidance of words like always, never and seldom in M.C. Questions—this is very important. Such wording represents sloppy thinking and examining and is condemned in all the standard works on the subject (some of which, at least, one would expect any examiner using this technique to be familiar with in some detail).

His third point, while attacking one fallacy, represents another. M.C.Q.'s should be based neither on the context of lectures as such, nor on "commonly available reputable textbooks"—but on a proper critical analysis, largely in behavioural terms, of what the student should be able to do at the stage at which he is being examined. Neither current lectures nor textbooks accurately represent this.

Mr. Stubbs is correct in pointing out that a student's examination results represent his ability at taking examinations as well as his knowledge of the subject (as well as the effect, if any, of his teachers, and the imperfections of the examination technique used amongst other factors). However, he is wrong in thinking that the element of irrelevant gamesmanship is of peak importance with M.C.Q. This is very definitely not so: any student taking an M.C.Q. examination has the right to expect the details of the marking system (including the penalty system against guessing), explained to him fully before taking the examination. When this is properly done, there is a much lower "gamesman-

ship" effect in an M.C.Q. than in any other form of examination. When this is not done, it represents only the examiner's innocence of the details of the technique he is using and the sort of wistful wish to bemuse the candidate unnecessarily that seems so inexplicably common amongst examiners.

Medical schools have suffered, more or less since their inception, from the handicap of relying on amateur teachers and especially on amateur examiners. The situation is improving, but has a long way to go yet.

Yours faithfully,

MICHAEL A. SIMPSON.

York Clinic, Guy's Hospital.

59 Club Dinner

SIR,—The 59 Club dinner has been arranged this year at "The Anchor", Bankside, S.E.1, on Saturday, 6th March, at 7 for 7.30 p.m.

Yours faithfully,

JOHN RICKETT.

51, Romsey Road,
Winchester, Hants.

Name the Boat

SIR,—In a few weeks' time the keel of the Boat Club's new racing VIII is to be laid at Putney. As most of the money for this boat was generously donated by your readers, we wish to invite them to put forward their suggestions for its name.

In the past, celebrated Guy's men have been honoured—"Sam Wilkes" is our current 1st VIII boat, and "Guy" our coxless IV. We look forward to receiving your readers' suggestions through the courtesy of your columns.

Yours faithfully,

M. J. GLEESON.

East Wing,
Guy's Hospital.

SPORT

RUGBY

GUY'S v. METROPOLITAN POLICE

Saturday, 30th January. At H.O.P.

Result: Lost 0—12.

Guy's faced a strong Police XV on a wet and heavy pitch, following prolonged rain. The Hospital's team showed one change on the right wing, where Paul Board replaced an injured Brian Armstrong.

In the early phases of the game, it soon became apparent that the Hospital would have difficulty in obtaining possession in the tight scrums and lines-out against a much bigger Police eight. The short throw to Stuart at the front of the line often paid off, but other jumpers were too well marked. In the loose, possession was more even with both sides finding it difficult to control the ruck. Croft worked hard at the base of the scrum but was provided with few clean heels.

It was soon obvious that the main threat in the Police's attack was the strong running of their three-quarters, especially the fly-half. The latter often seemed able to make the outside break, and only decisive tackling by the centres or over-ambitious handling prevented successful penetration. Territorially, in the first half, play remained in the Hospital's half, and from this position the Police were able to kick two penalty goals and score an unconverted try.

In the second half, the Hospital's pack found they were able to drive the ball through from the line-out and Gibson and Fallowfield were much in evidence in this respect. Most breakaways gained several yards and one drive in-field set up a ruck near the posts, and Jones was just wide with an attempted dropped-goal. At other times, Guy's running was too lateral and lacked any hidden change or straightening of direction, which, on a wet day, is often testing to an opposition's defence. Metropolitan Police added to their score with a dropped-goal in the closing stages.

Team: M. Danford, P. Board, T. Druett, A. Campbell, D. Barough, D. Jones, C. Croft, G. Evans, T. Gibson, D. Stuart, K. Rigg, R. Burt, J. Baker, M. Forbes, A. Fallowfield (capt.).

SENIOR HOSPITAL CUP SEMI-FINAL

versus ST. BARTHOLOMEW'S HOSPITAL
at RICHMOND ATHLETIC GROUND
on FEBRUARY 16th, at 3 p.m.

2nd ROUND INTER HOSPITALS JUNIOR CUP
GUY'S v. CHARING CROSS

Guy's took the field on a still, cold afternoon, with an experienced side, containing four regular 1st XV players and three who had played many games for the 1st XV in previous years.

After three minutes, Rex Yetton put over a penalty from in front of the sticks after an offside ruling at the first scrummage. Moments later, Charing Cross won the ball from a scrum on their line after a knock-on, but Peter Mathews at scrum-half, swept the ball from his opposing number's hands to cross over under the posts. Yetton converted.

Guy's, although winning most of the ball from the line through good jumping by Steve Challacombe, found that there was plenty of possession to be won from good "loose rucking".

A heel against the head in the Charing Cross "25" gave Chris Bates the opportunity to battle through for a try in the middle which was easily converted. At half-time the score was 19—0, thanks to tries late in the first half by Tim Higenbottam and Paul Board.

Only minutes after starting the second half, Guy's forwards were in full stride again, giving a good ball to the three-quarters. With the advantage of clean, quick possession, the Guy's backs had little difficulty in outplaying the Charing Cross threes. First to cross the Charing Cross line in the second half was Trevor Druett after a fine run. Just after restarting, Higenbottam, on the wing, scored a splendid try after a 30-yard sprint to the corner.

For the last half-hour, Guy's had little trouble in crossing the Charing Cross line, the Charing Cross side now losing all hope. Tries in this onslaught by Paul Board (3), Ken Rigg (2), Rex Yetton (2), Tim Higenbottam (2), Trevor Druett (2), Chris Bates and Peter Swift contributed to the final score of 67—0.

Let us hope this form stays with Guy's until the Junior Cup is safely back at Guy's.

WATER POLO

UNITED HOSPITALS WATER POLO LEAGUE, 1970

1st Team

Last term saw Guy's successfully retain the U.H. Cup. The second year in succession that Guy's have won the League.

The opposition this year proved even less difficult to overcome than in previous years, and only Mary's afforded any obstacle. The Guy's team was essentially the same as in the past year except that Bruce Wright replaced Keith Howard in goal.

Due to cancellations by other teams, only six out of a possible ten games were played, but all were won, largely due to competent team work of Northcott, Challacombe and Jones, in "midfield" and on the two-yard forward line. A formidable defence of Bevis as back and Wright as goalkeeper, helped considerably to keep the away goals down. Adkins and Skinner proved worthy substitutes.

Team: R. Jones, S. Challacombe, G. Northcott, B. Wright, C. Bevis.
Substitutes—M. Adkins and D. Skinner.
Guy's vs. King's. Won 16—1. Return, w/o.
vs. London. Won 12—1. Return, won 8—2.
vs. Mary's. Won 7—5. Return, won 2—1.
vs. Bart's. Won 12—1. Return, w/o.

2nd Team

The team played well by capitalising on the hard shooting of Adkins, who was ably supported by Skinner, Clark and Sands. Cottrill and Bowering took it in turns to strengthen the side. It was unfortunate that fixtures were plagued by so many cancellations, for it made it difficult for the team to strike up a strong winning rhythm and also the lack of match practice may show when first team replacements are needed for the U.L.U. League. However, overall, match results were satisfying.

Team: M. Adkins, P. Skinner, J. Clark, T. Sands, R. Bowering, M. Cottrill. Results to be confirmed.

3rd Team

Basically a "fresher" side, limited by a lack of match experience, they played well, by compensating with enthusiasm and energy against strong opposition. Captained by an "experienced" Bowering, both Cordingly and Hellyar played strongly in "midfield": the two strongest swimmers, they are good first team prospects. Rowlands supported well with his own strong, subtle underwater approach to the game. Peel, Bates and Hunter completed a team which was unlucky in not obtaining better results.

Team: R. Bowering, F. Cordingly, A. Hellyar, M. Rowlands, J. Peel, C. Bates, C. Hunter.

Results to be confirmed.

GUY'S I v. MARY'S I

Lost 5—10.

The first match of the U.L.U. League last Tuesday against King's I was a walk-over for Guy's, who collected full points as the King's team was incomplete. I am pleased to report that the Guy's all-female Supporters' Club turned out in force for both this match and the one against Mary's.

Guy's I team for the match against Mary's was an aggregation of first, second and third team players. In view of this, the match was not bad at all. Our team suffered most in lack of speed and inadequate practice together. With more training, we should be able to produce several good teams as we have done previously.

The first half of the match, which consisted of four five-minute quarters, was disheartening for Guy's when we were 5—0 down. However, in the last quarter, some particularly good shots from Northcott, Challacombe and Bevis gave us some well deserved goals. Due to good backing from Sands, Clark, Cordinglay and Bowering (goal), the final score was 10—5 to Mary's.

Unfortunately, a number of our best first team players have now qualified and moved on. We have thus lost Roddy Jones, Mark Adkins and Bruce Wright, amongst others. A number of freshers, including Andy Hellyar, have shown keen interest, and with training we should be able to compile two teams at least to represent Guy's in the near future.

R.J.B.B.

HOCKEY

GUY'S 1st XI v. ROMFORD

At Cobham.

Result: Draw 0—0.

Thanks to some overtime work by a thoughtful committee, Guy's managed to procure the superb Westminster ground for this fixture so that work could start to try and save the appalling pitch at H.O.P.

It is sad to relate, however, that, on this day, the hockey never at any stage matched the standard of the pitch. Both teams obviously had exactly the same problem of adequate defence, but unco-ordinated and inconsequent attack. The game became a very tedious uninspired affair with no player excelling at any part of the game.

On this large pitch the Guy's wingers were a sad disappointment considering just how good a service they were given straight out of defence.

Let us hope for a higher standard of play in the approaching cup matches.

Team: R. Burns, R. Clark, D. Crafts, N. Matthews, P. Calvert, R. Fell, P. Nichol, J. Walker, P. Duckworth, R. Clark, P. Wilmer.

D.R.C.

1st XI v. WALLINGTON

Result: Won 3—1.

With the sophistication of cowboys running down cattle, a weak Guy's side conquered every element to win this game in the middle of a monsoon. Smoke signals for Calvert went ignored, and while the solitary umpire was hiding behind the cloud, the ten heroes fought bravely to a half-time 1—0 lead.

Big chief Fairbrother from the southern counties, arrived to bring order to the battleground, but by this time, Fell and Bob Clark had learnt the rules and were hitting back. Nicol bared his chest to make a save Bobby Moore would have been proud of, while Robert Clark was tattooing the "sign of the stick" across our opponents' goalkeeper's forehead. This was really a mis-timed scalping attempt.

Amidst the hard riding, goals were scored by Walker, Fell and Clark, and the day was won. Perhaps the roast potatoes scalded our tongues, for after a quick pow-wow and a thoughtful peace-pipe, we left the reservation for Calvert's court-marshal.

Team: R. Burns, R. Fell, R. Clark, R. Clark, J. Walker, J. Shutes, P. Nicol, P. Duckworth, N. Matthews, C. Crawshaw, A. Deserter, P. Calvert.

R.W.B.

TABLE-TENNIS CLUB

THE LADIES' EVENING

On Thursday, 28th January, ten ladies took part in the "Ladies' Championship of Guy's Hospital". This is only the third competition of this type ever to be staged at Guy's.

In the first round there was a tremendous match between Jill Harris and Caroline Rix. In fact, this turned out to be the clash of the tournament, and the suspense lasted until the final point. Jill won 21—17, 9—21, 21—18.

Jill then went on to reach the quarter-final, where her opponent was Miss Fiona Odle, the reigning champion. Jill gave Fiona the fright of her life before the champion came through 21—19, 14—21, 21—13.

Fiona Marsh, Claudia Roe and Elizabeth Ryman were the other three ladies who reached the semi-finals.

Both semi-finals were rapid affairs, Fiona Odle finding her touch against Fiona Marsh, and Elizabeth Ryman proceeded to the final with a brilliant performance against Claudia Roe.

The final was a repeat of last November's final, although this time Fiona's victory over "Liz" Ryman was much easier than last time.

In the ladies' doubles the first real clash was in the semi-final between Fiona Odle & Liz Thomas, and Sheila Owen & Ann Rothman, the latter pair coming through by 21—18, 9—21, 22—20. Elizabeth Ryman & Caroline Rix came through without much opposition, and beat S. Owen & A. Rothman in the final by 21—19, 21—16.

It should be mentioned that Fiona's victory was her third in this type of tournament and she has yet to be beaten. It is indeed a great achievement.

The new ladies' doubles champions are Liz Ryman & Caroline Rix, and this formidable pair is going to be hard to beat.

It was really wonderful to see so many ladies in action. They were encouraged by many male supporters, who cheered every point.

On Thursday, 28th February, we are staging a mixed doubles tournament, and already there have been a large number of entries. If you are interested in participating, please contact me as soon as possible. We will present a cup to each of the two winners, so there is everything to play for.

Good luck.

Steve Willis.

HOSPITAL INFORMATION

GUY'S HOSPITAL BOARD OF GOVERNORS

Applications are invited for the post of **Registrar in Clinical Pathology** at Guy's Hospital for the period 1st February to 30th September, 1971. Applications, together with the names of two referees or two recent testimonials should reach the Superintendent, Guy's Hospital, S.E.1, by **15th February, 1971.**

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited from registered dental practitioners for the appointment of **Lecturer (Full-time) in the Oral Surgery Department,** with duties commencing as soon as possible. Salary within the range of £2,450 to £3,926 with superannuation. Forms of application are obtainable from, and should be lodged with the Dean, Guy's Hospital Dental School, London, S.E.1, not later than **Tuesday, 2nd March, 1971.**

GUY'S HOSPITAL

HOUSE APPOINTMENTS

MARCH 1st, 1971

House Physicians

Dr. Mann, Dr. Scott and Dr. Clark — Mr. J. H. Pitt-Payne, 3 *months*; Mr. W. J. Morris, 6 *months*

Dr. Hardwick, Professor Trounce, Dr. Cameron and Dr. Ogg — Mr. P. G. McAndrew, 3 *months*; Mr. T. W. Higenbottam, 6 *months*

Dr. Houston, Dr. Knight, Dr. Deuchar and Dr. Grimble — Mr. R. H. Savage, 3 *months*; Miss A. W. Godsmark, 6 *months*

Dr. Kauntze, Dr. Joiner, Dr. Burry and Dr. Sowton — Mr. G. T. Cheney, 3 *months*; Mr. J. Rawlinson, 6 *months*

Professor Buttterfield, Dr. Lessof and Dr. Grahame — Mr. E. J. Will, 3 *months*; Mr. R. A. Gude, 6 *months*

House Surgeons

Professor Sir Hedley Atkins — Mr. R. A. Blackwood, 3 *months*

Mr. Blackburn and Dr. Wayte — Mr. C. G. Rowland, 6 *months*

Mr. Lawrie — Mr. B. R. Kenning, 3 *months*

Mr. Glover and Dr. McArthur — Mr. D. F. M. Thomas, 6 *months*

Mr. Beard — Miss D. C. T. Watson, 6 *months*

Mr. Maynard and Dr. Wayte — Mr. M. H. Faulkner, 3 *months*

Mr. Ellis — Mr. J. L. Bates, 6 *months*

Mr. O'Flynn and Dr. McArthur — Mr. M. F. M. Bamford, 3 *months*

House Surgeon to the Breast and Plastic Surgery Units

Mr. T. J. Storrs, 3 *months*

Gynaecological House Surgeon

Mr. S. J. D. O'Keefe, 6 *months*

Throat and Ear House Surgeons

Mr. J. A. Quant, 3 *months*
Miss G. L. Hoare, 6 *months*

Orthopaedic House Surgeons

Mr. A. J. West, 3 *months*
Mrs. L. J. Rockall, 6 *months*

S.H.O. to the Renal and Transplant Units

Mr. R. D. Forrest, 3 *months*

Genito-Urinary House Surgeons

Miss A. M. Tihanyi, 3 *months*
Mr. J. E. De Carteret, 6 *months*

Children's House Physicians

Mr. M. E. Worby, 3 *months*
Mr. N. C. B. Howell, 6 *months*

Casualty Officers

Mr. W. J. Owen, 3 *months*
Mr. A. M. Seal, 3 *months*
Mr. M. J. H. Hillier, 6 *months*
Mr. M. Horrocks, 6 *months*
Mr. F. O. Nwator, 6 *months*
Mr. A. S. Purandare, 6 *months*

Resident Obstetricians

Mr. C. Wright, 3 *months*
Mr. J. B. Kelynack, 6 *months*

Neurological House Physician

Mr. J. F. Price, 6 *months*

Dermatological House Physician

Mr. D. Ogilvie, 6 *months*

House Physician in Child Psychiatry

Miss R. P. Doody, 6 *months*

House Surgeons to the Thoracic Unit

Mr. T. Treasure
3 *months*
Mr. A. Hirsh
6 *months*

House Physician in the Department of Psychological Medicine

— 1.4.71—30.9.71
— 1.4.71—30.9.71
(Appointments to be made 16.2.71)

Resident Anaesthetists

Miss E. Spark
3 *months*
Mr. R. P. H. Dunnill
3 *months*
Miss A. M. Skelton
6 *months*
Mr. J. R. Wedley
6 *months*

Senior House Officers to Nuffield House

Mr. J. B. Bingham
3 *months*
Mr. J. A. Vale
6 *months*

Children's House Physicians at Eveliaa Hospital

Mr. I. F. Roberts	1.12.70—31.5.71
Mr. G. Stern	1. 2.71—31.7.71
Mr. A. C. L. Fraser	1. 4.71—30..971

Casualty Officers at Evelina Hospital

—
6 *months*
Mrs. B. Mallya
3 *months*

ST. OLAVE'S HOSPITAL

House Physicians:
Mr. M. M. Henry
3 *months*
Mr. R. J. Rycroft
6 *months*
House Surgeon:
Mr. G. C. K. Nkwazi
3 *months*
Senior House Surgeon:
Mr. J. M. Wyllie
3 *months*
Gynaecological House Surgeon:
6 *months*
S.H.O. in Psychiatry
Miss M. Greenwood
6 *months*

NEW CROSS HOSPITAL

House Physicians in General Medicine and Geriatrics
Mr. B. M. Crichton
3 *months*
Mr. J. R. M. Ross
6 *months*
Orthopaedic House Surgeons:
Mr. P. L. Neustatter
3 *months*
Mr. M. G. Sutton
6 *months*
Senior House Officer to Rehabilitation Unit:
Mr. A. Bhoomkar
6 *months*

BECKENHAM HOSPITAL

House Physician:
Mr. N. I. McNeil
6 *months*
House Surgeon:
Readvertised.
6 *months*

LEWISHAM HOSPITAL

House Physician to Dr. Price:
Mr. M. F. Shiu
3 *months*
House Surgeon to Dr. Lynn Evans:
Mr. N. Longhurst
3 *months*
House Physician to Dr. Roberts:
Mr. J. A. R. Pook
3 *months*
House Surgeon to Mr. Ivo-Smith:
Mr. P. M. Carter
3 *months*
House Surgeon to Mr. France, Mr. Bingold and Mr. Monty
Readvertised.
House Surgeon to Mr. Le Brun:
Mr. A. K. L. Addison
6 *months*
House Surgeon to Mr. Cavendish:
Mr. M. A. Mansell
6 *months*
House Physician to Dr. Llewellyn Smith:
Mr. M. J. Forbes
6 *months*

HITHER GREEN HOSPITAL

House Physician in General Medicine and Infectious Diseases:
Mr. D. N. Morton
3 *months*
Mr. M. Taylor-Pearce
6 *months*

MILLER HOSPITAL

House Physician to Dr. Hartley and Dr. Bassdone:
Mr. M. A. Knight
3 *months*
Mr. A. G. Samuel-Gibbon
6 *months*
(S.H.O.) Mr. G. McL. Cochrane
6 *months*
House Surgeon to Mr. Candy and Mr. Gwynne Evans:
Mr. M. N. Vellacott
3 *months*
House Surgeon to Mr. O'Flynn and Mr. Fyffe:
Miss C. Thorne
3 *months*

ORPINGTON HOSPITAL

House Surgeon with Physical Medicine:
Mr. B. F. Akasheh
3 *months*
House Surgeon with Orthopaedics:
Mr. C. J. Noble
3 *months*
House Surgeon with Ophthalmology to Mr. Walker Brash and Mr. Chivers:
Readvertised

PEMBURY HOSPITAL

House Surgeon to Mr. Gibson and Mr. Lavy:
Mr. J. M Morsman
3 *months*
Readvertised.
6 *months*
House Physician to Dr. Miller and Dr. King:
—
3 *months*
Mr. J. M. Ruddock
6 *months*

ST. HELEN'S, HASTINGS
House Physicians:
Mr. N. J. Lattimer
3 *months*
Readvertised.
6 *months*

ST. NICHOLAS, PLUMSTEAD
House Physician to Dr. Scott:
Mr. R. D. G. Carmichael
3 *months*

P. J. HELLIWELL,
Superintendent.

PASS LIST

ROYAL COLLEGE OF PATHOLOGISTS

F.R.C.Path.

W. F. Whimster — I. I. Zayid

ROYAL COLLEGE OF SURGEONS OF ENGLAND

Primary F.R.C.S.

J. A. Clarke — K. B. Hughes
J. E. Dussek — B J. Rowlands

F.R.C.S.

P. G. Ransley — R. L. Strickland
J. B. M. Shepherd — N. W. D. Walshaw

FACULTY OF RADIOLOGISTS

F.F.R.

J. S. M. Beales — D. J. Lintott

UNIVERSITY OF LONDON

Special Second Examination in Dental Surgery

I. C. Dutton — Ciaran P. McCarthy
S. B. Frost — T. P. McDonnell
R. Hartley — Geraldine F. O'Connor
J. R. T. Hayward — D. R. Pickering
R. J. Ibbetson — Anna M. Quilty
N. M. King — R. J. Robinson

Third B.D.S.
Honours

B. S. Avery — Joanne C. Timmis
P. G. Jenkins — G. R. Waterhouse
P. D. Robinson — G. N. Wolffe

Pass

Rosemary P. Bailiff — R. P. A. Lovell
R. D. Barough — I. J. McClure
J. C. Beckerson — D. J. McConnell
G. P. Booth — J. P. McDonald
D. K. Briggs — J. C. Miller
Margaret E. Cartwright — P. J. M. Moulder
F. D. K. Chan — G. P. Northcott
C. J. Clare — J. N. Palfreyman
J. A. Cope — K. Pittel
D. R. Crafts — D. Powell
J. L. Curtis — Mary D. Powell-Cullingford
J. P. Dine — Sheila M. Ratcliffe
P. A. Epps — Emily E. Richards
A. M. Evans — P. S. Richardson
P. J. Evans — D. Searle
C. R. Farrant — P. Sharples
Felicity J. Francis — J. Stock
Jane R. Goodman — Ann V. Tapsell
H. Greenaway — J. W. Toplis
W. F. Haines — A. J. Walter
Hilary C. Hodge — Pamela J. M. Watson
R. J. Lane — M. G. Watt
Mary Law — Susan J. Wilson
I. H. Learner — B. A. Wooster
R. V. Leeburn — B. A. Wright
B. P. Levy

Part I

I. Bamford — Elizabeth S. Poulton
Elizabeth J. Bodycombe — C. R Ryan
D. R. Cottam — D. R. Thompson
A. P. P. Edwards — S. H. Troughton-Smith
A. K. Godman — R. L. Wood
A. T.-L. Lee

Part II

J. Ah-Moye — G. Nicholas
D. E. Barker — J. C. A. Owen
Gillian M. Barker — A. Parker
K. V. Bell — N. A. M. Pearce
E. P. Brown — Diane Plamping
M. J. Carter — T. E. Reynolds
J. A. Colman — R. G. Russell
D. W. S. Davies — M. A. Samji
Penelope J. Davis — T. P. Sands
Diane Dennison — G. F. Sartory
G. J. P. Dewe Mathews — M. L. Schaller
G. I. Eikrem — M. J. C. Shepherd
G. W. Emery — A. A. Skry
G. M. Hall — J. Standish
Julie A. Howlett — S. H. Troughton-Smith
O. L. Jeeves — Lynne A. C. Turner
Hazel K. Kirk — J. Y. Wakeham
R. C. Knowles — Katherine M. Walter
Sandra B. Lee — T. J. Walters
N. S. McLeod — Elizabeth C. Williams
Maire E. Morton — N. A. K. Williams
K. J. J. Moseley — S. A. Winfield

Part III

R. N. Allen — Rowena Oakes
Christine A. Clark — S. D. W. Stuart
Dorothy R. Evans — J. W. Tennant
Patricia M. Fernandez — A. P. P. Walker
B. C. Ford — T. J. L. Want
E. T. Harland — S. M. P. Wright
A. A. Holland

UNIVERSITY OF CAMBRIDGE

M.B., B.Ch.(Camb.)

T C. Bushell — W. G. Sherwood

UNIVERSITY OF OXFORD

B.M., B.Ch.(Oxon)

A. K. L. Addison — Priscilla L. Pantin
Celia G. Bissenden — M. J. Reilley
R. A. Blackwood

SOCIETY OF APOTHECARIES OF LONDON

Diploma in the History of Medicine

H. N. Levitt

PERSONAL

HOUSE TO LET—54 Dunnon Road, Forest Hill, S.E.23. Comprising 2 reception, kitchenette, cloakroom with W.C., 4 bedrooms, bathroom and separate W.C., garage, central heating throughout. Rent £520 p.a. and rate at present £93 p.a.). Enquiries to Mr. Loomes, Counting House, Guy's Hospital ('Phone: 407 3662, Ext. 60).

Three-bedroom span flat, Blackheath. Full gas central heating. Vacant end March. Tel: 852 0203 (evenings).

BIRTH

OAKENFULL—On 28th January, 1971. At the Sevenoaks Maternity Hospital, to Rosemary (née Boddy) and Stuart Oakenfull, a son, Dominic John Lawson.

DEATH

WEATHERELL—On 28th January, 1971, at Royal Victoria Hospital, East Grinstead, Mona Weatherell, S.R.N. (Evelina and Guy's, 1949—1960).

CHANGE OF ADDRESS

Mr. W. R. O'Flynn, 9, Devonshire Place, London, W1N 1PB. Tel: 01-936 4054; (Home) 01-852 0275.

GUY'S HOSPITAL GAZETTE

EDITORS N. D. S. BAX and A. M. TURNER
NEWS EDITORS R. M. DARLING and J. L. LEWIS
SPORTS CORRESPONDENT A. M. ROYSTON
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TEN PENCE VOLUME 85 NUMBER 2155

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Thamesmead

The L.C.C. announced proposals for building this new town for 60,000 people in 1964. Since then Guy's has become increasingly linked with Thamesmead. This issue of the *Gazette* contains a symposium about Thamesmead and the 8th to the 12th March will be a Thamesmead Week at Guy's. Activities that week include an exhibition, film and tape-slide programme in the Gordon Museum and a visit to Thamesmead.

The Combined Round on Friday, 12th March (2 p.m. in the Physics Theatre) will be a Thamesmead teach-in under the chairmanship of Professor Butterfield. This will be his last Combined Round. Details of the dates and times of these activities appear on page 107.

Of the authors of the articles in this issue, Professor Butterfield is the Professor of Medicine at Guy's and has been intimately connected with Thamesmead from its conception. Dr. Higgins is the first general practitioner at Thamesmead and also head of the Department of General Practice at Guy's. Mr. Johnson is the first Thamesmead dentist, also holding an appointment in the Guy's Dental School. Miss Monica Nath is a medical student from Bristol University and Mr. Curwen works in the Department of General Practice as well as

being secretary of the Joint Health Services Advisory Committee for Thamesmead.

Thamesmead Week offers everyone in Guy's a unique opportunity to see medicine being planned and developing in harmony with a new community. It is an opportunity that should not be missed.

Stand up, and be not recognised

The smell of success : a student hears his name pronounced by a consultant. It is sweet as roses and, like the delight from receiving a beautiful bouquet, the swoon comes from the promise of future benefits. Perhaps the possibility of such joy is as it should be and it is desirable that most of the members of a firm should be despondent when, on the last of thirteen successive weekly ward rounds, the chief of the outfit asks them their names, gratifying the recognised few with their fellows' envy. The very famous Dr. Johnson said: "it is better that some should be happy, than that none should be happy, which would be the case in a general state of equality." But need the inequality start at so low a level? All would surely aspire to higher levels of achievement if they saw that their teachers and judges remembered them for past efforts. One of the most effective discouragements is to realise that no one concerns himself with what you do so long as it is not unmentionably sinful.

Now it is not to be expected that consultants and registrars will remember the names of everybody when they see them for only about four hours a week. It is probable that all students look the same to their teachers. So, to skirt around the problem of the failure of human memory and the understandable dismay of the student on discovering he has made no more impression than a faceless, nameless automaton, let us have name badges like those of the house staff and nurses for students.

Dr. Walter Merivale

It is with great sadness we announce the death of Dr. Merivale, on 10th February. His contribution to Guy's was enormous and his absence will be deeply felt. We extend our sympathies to his widow and children. An obituary appears on page 87.

Memorial Service

A memorial service for the late Dr W. H. H. Merivale will be held in the Guy's Hospital Chapel on Monday, 15th March, 1971, at 12.30 p.m.

NEWS IN BRIEF

The Cup-Final Rag

With the 1st XV victory over St. Bartholomew's, Guy's are once again in the final of the United Hospitals' Cup which is being held at Richmond on 3rd March. The team is always supported in the final by many past and present members of the Rugby Club and friends of the hospital, but they are usually overshadowed by the rather more conspicuous support from the Students' Rag, which in the past few years has been unnecessarily violent, harming both the reputation of Guy's students and the match itself.

A brief history of recent Rags may be of interest : A nurse suffered a fractured pelvis in 1966. Two years later a car had to be resprayed and the following year another car needed the same, a coat had to be replaced and a fire extinguisher was dropped 20 feet through a skylight at St. Bartholomew's, narrowly missing a doctor and a nurse. The bill for that year was £120 to Guy's Students' Club which was £50 less than the cost of the damage in 1970 done at the ground alone, where innocent spectators were involved in the dental plaster exchange. In addition, several hundred pounds worth of damage was inflicted on both hospitals before the match.

The Clubs' Union, supported by the Rugby Club, have passed a resolution dissociating themselves from the Rag, and discouraging students from taking part. It will approach the other hospital involved, either Westmnister or St. Mary's, to attempt to prevent a repetition of recent years' disasters.

Coach tickets to the match are now available at the Medical School Office.

The Junior Hospital Doctors' Association

An extraordinary general meeting of the Students' Club was held on 12th February, 1971, to decide whether the Students' Club should join the Junior Hospital Doctors' Association. Among those present at the meeting were the President of the Students' Club, Mr. Beard, the Secretary, Mr. Cook, and the Student President, Bruce Dick.

Mr. Dick started the discussion by giving a brief history of the J.H.D.A. He emphasised that four students were included in the 16 members of the Executive Council. Money collected from students was being used solely to finance student projects such as student locums and increased grants. The cost to the Students' Club of joining the J.H.D.A. would be £10 per 100 students, and Guy's would not sever connections with the B.M.S.A.

Mr. Beard said that the medical profession is dissatisfied with the present negotiating bodies, which include the Central Committee of the B.M.A. He felt that the Students' Club should therefore join another negotiating body in addition to the B.M.S.A.

A motion to join the J.H.D.A. was carried by a large majority.

It is interesting to note that although this was an important decision for the Students' Club, about 48 students and four council members were present. This represents only 10 per cent of the medical students.

Redecoration of New Guy's House

As users of New Guy's House have probably noticed, the building is currently being redecorated. Although it has already been redecorated once since its opening in 1961, the present operation is the first thorough overhaul of the building dealing with all the alterations and repairs to fittings and furniture which have become necessary. The top four wards have been completed (i.e. Esther, Naaman, Patience and Samaritan), and work is currently in progress on Luke ward.

Queen is being used as the "change ward", i.e. patients from wards to be decorated are transferred to Queen while work is in progress. Queen and Christopher will be the last to be redecorated. The first and second floors are not included in the programme, but the Casualty Department floor is. The cost for each ward is about £2,000.

"The Knack"

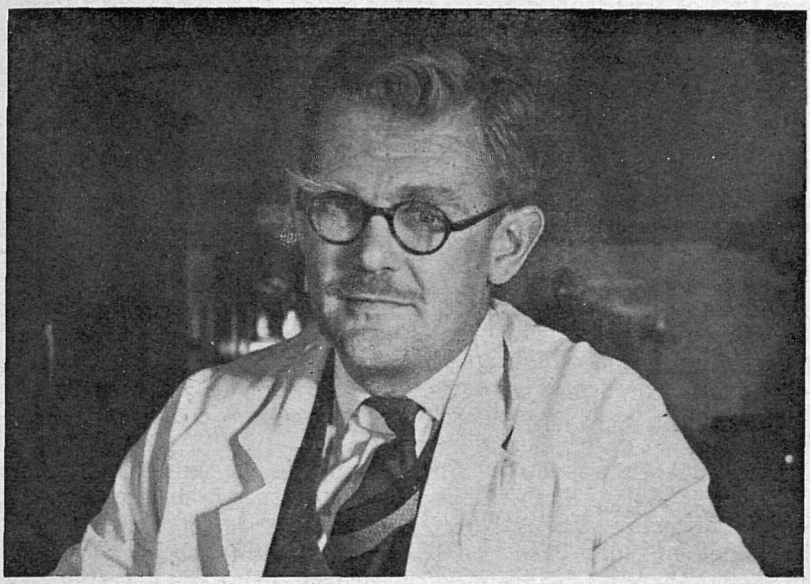
The Theatre Club's next production is "The Knack" by Ann Jellicoe. It will run from 22nd to 26th March, starting at 7.30 p.m. in the Physiology Theatre. Tickets are available from Suzanne Coates, c/o Nurses' Home.

GUY'S DIARY

MARCH

1	M	1.00	Clinical Lecture. Mr. SALMON. "The Chronically Discharging Ear."
4	Th	1.00	Clinical Lecture. Mr. LAWRIE. "Surgery in the Newborn."
5	F	2.15	Combined Round. Professor POLANI. "Anomalies of Sex Development."
9	Tu	1.00	Clinical Lecture. Mr. FLANNERY. "Retroperitoneal Fibrosis."
11	Th	1.00	Clinical Lecture. Mr. BLAIKLEY. "Gynaecological Cancer."
12	F	1.00	Clinical Lecture. Dr. LESSOF.
		2.00	Combined Round. Professor BUTTERFIELD and Dr. HIGGINS.
			Thamesmead Teach-In. (See separate notice.)

OBITUARY
Dr. W. H. H. MERIVALE



Dr. Walter Herman Hodgson Merivale, Director of the Department of Clinical Bacteriology and Virology, died on 10th February, 1971, at the age of 53, as the tragic result of a road accident. With his passing, Guy's has lost one of the dominant personalities in the contemporary life of the Hospital.

A student of St. Thomas' Hospital, Dr. Merivale obtained the diplomas of M.R.C.S., L.R.C.P., in 1939, and after holding House appointments at the Royal Victoria Hospital, Bournemouth, he graduated M.B., B.S. (London) in 1940, with honours in Obstetrics and Gynaecology. Following a short period in general practice, he realised his ambition to enter for a career in pathology when, in 1941, he was appointed Junior Assistant Pathologist to the war-time Emergency Medical Service. During the course of this appointment, he worked in the laboratories of the Sutton and Cheam General Hospital and Botley's Park Hospital, and in January, 1942, he obtained the diploma of M.R.C.P.

Joining the R.A.M.C. in October, 1942, he continued his work in pathology throughout his service career. His overseas duties took him first to Normandy in June, 1944, and later to India. He received recognition as a Specialist in Pathology, and was promoted to the rank of Major. On returning to England in 1945, he was posted as Officer Commanding the District Laboratory at Catterick and Deputy Assistant Director of Pathology, Northumbrian District, Northern Com-

mand. While at Catterick, he was able to devote most of his time to clinical chemistry, upon which his interests had at that time become fixed. He returned to civilian life in 1947, and was appointed Pathologist to the Newcastle General Hospital.

In 1948, Walter Merivale came to Guy's. His first appointment was that of Assistant to the Director of the Department of Clinical Pathology, and he was promoted three years later to the University Readership in the same Department. During his early years at Guy's, he engaged in research in the field of clinical chemistry, and his many publications, including chapters in various textbooks, were mainly concerned with disorders of carbohydrate metabolism, steroid excretion, and disturbances of water and electrolyte metabolism.

On the retirement of the late Dr. F. A. Knott in 1955, Dr. Merivale was appointed Consulting Clinical Pathologist, and succeeded to the Directorship of the Department. He continued to take an active interest in clinical chemistry at a time when the constantly increasing demands on this service necessitated the introduction of automated techniques, and, by contrast, he also undertook the arduous duties of Control of Infection Officer. To this latter task, which carried a considerable burden of responsibility following the opening of New Guy's House, he devoted himself with tremendous energy and enthusiasm.

In 1964, he was elected F.R.C.P., and in the same year became a Founder Fellow of the College of Pathologists. In recent years, despite his many other activities, he found time to serve as Examiner in Pathology in the Primary F.R.C.S. examination, and as Examiner in Bacteriology to the Institute of Medical Laboratory Technology. He was also much concerned in the planning of the new laboratories in the Tower Block which, sadly, he will never see. Perhaps his greatest contribution to Guy's was the establishment of a much needed virology laboratory which, though still in its infancy, is likely to grow and to stand as a memorial to his name. With still further demands on the clinical pathology services, division of the Department into its separate components at last became inevitable, and, for the remaining years of his life, Dr. Merivale served as Director of the newly-named Department of Clinical Bacteriology and Virology.

An exuberant personality, Walter Merivale will be remembered as a tall, impressive figure whose masculine appearance readily earned him the name of "Dr. Verimale" in a number of Residents' Plays. He had a remarkable flair for conversation combined with an infectious laugh which endeared him to his colleagues. As a teacher, he rightly emphasized the clinical aspects of his subject, and his frequent recourse to humorous anecdotes did much to induce a state of wakefulness in his students as well as to gain their affection. His interests outside medicine included a passion for sailing and a love of the Opera. With his wife, Jo, he loved to entertain friends generously, and anyone who attended a party at their home in Harrow-on-the-Hill was assured of a memorable evening. His friends at Guy's will extend their heartfelt sympathy to his wife and to his four children, and hope they will derive comfort from the knowledge that he contributed in full measure to the life of a great Institution. A.L.J.

THAMESMEAD SYMPOSIUM

1. Guy's and Thamesmead

Professor W. J. H. Butterfield

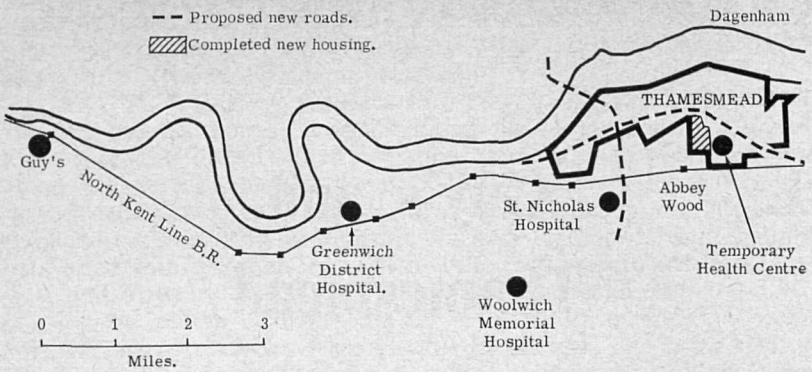
Background

In 1964 the L.C.C. announced their proposal to build a new town for 60,000 people, subsequently called Thamesmead, on the site of the old Woolwich Arsenal. At that time I had been discussing with Dr. Robert Smith, who had been seconded from the Wellcome Foundation to my department, the whole question of re-establishing interest in medical work in the community. The Bedford and Bermondsey surveys had brought home to me that if the demand for care for chronic diseases in an ageing population was to be met, more medicine and therapy would have to be carried out in the home. We were also disturbed by the tendency for every medical man and woman who failed to get a hospital appointment either to emigrate or to begin their professional career as a G.P. with the feeling that they had not "made the grade".

We therefore resolved to see if Thamesmead offered an opportunity for the establishment of an integrated (general practitioner—Local Health Authority—Hospital) medical service linked to an education programme. We thought of this in terms of medical students in the first instance, but it quickly became apparent that the educational component might be extended not only to dentists, nurses and physiotherapists, but a whole host of other careers in the medical care services.

Raising Moral and Financial Support

Robert Smith and I began a series of preliminary discussions with Medical Officers of Health and others concerned with health



Guy's, The Thames and Thamesmead

services in the locality of Thamesmead, with Members of Parliament and with people like Lord Taylor with experience of health service planning elsewhere. The reaction was generally favourable. The question was, could the integration be achieved? Was the project feasible? To answer these questions we persuaded the Nuffield Foundation, to whom we shall always be grateful, to finance a General Practice Research Unit. This was set up under Dr. Smith within the Department of Medicine and was given the task of exploring the possibility of establishing a planned integrated education-orientated medical care service for Thamesmead.

Making Plans

Our first step was to start a series of weekly or fortnightly discussion meetings which were held over a period of nearly two years. At first these were attended only by people with an immediate interest in the project, but as time went on, their scope widened to include, for example, architects, pharmacists and psychiatric social workers. Out of these meetings grew our first plan for the health services of Thamesmead, which was published in an article in the *Lancet*.

We had to settle what it was we wanted to offer Thamesmead's population when the town was eventually built, 10 to 15 years in the future. Two things were immediately clear—firstly that the standard of housing would be high, and this meant that it would be sensible to treat people at home wherever possible; secondly, that there was no prospect of a new hospital at Thamesmead. St. Nicholas Hospital, Plumstead, was barely two miles away, and the new Greenwich District Hospital was already being built.

Our first plan was for a centre where some 24 general practi-

tioners would be brought together as four group practices, having educational facilities for themselves and students and clinical facilities comparable to those in an outpatient clinic, with suitable laboratory support to reduce the burden on the local hospital out-patient clinics, and with consultant visits to the centre, where real consultations (with patients, G.P. and consultant present all together) could take place. In our original plan, this centre was to be supplemented with four or five smaller buildings dispersed in the community, where local health authority aspects of medical care (well-baby clinics, health education, etc.) could be carried out and where the doctors could be on duty each morning for urgent local calls.

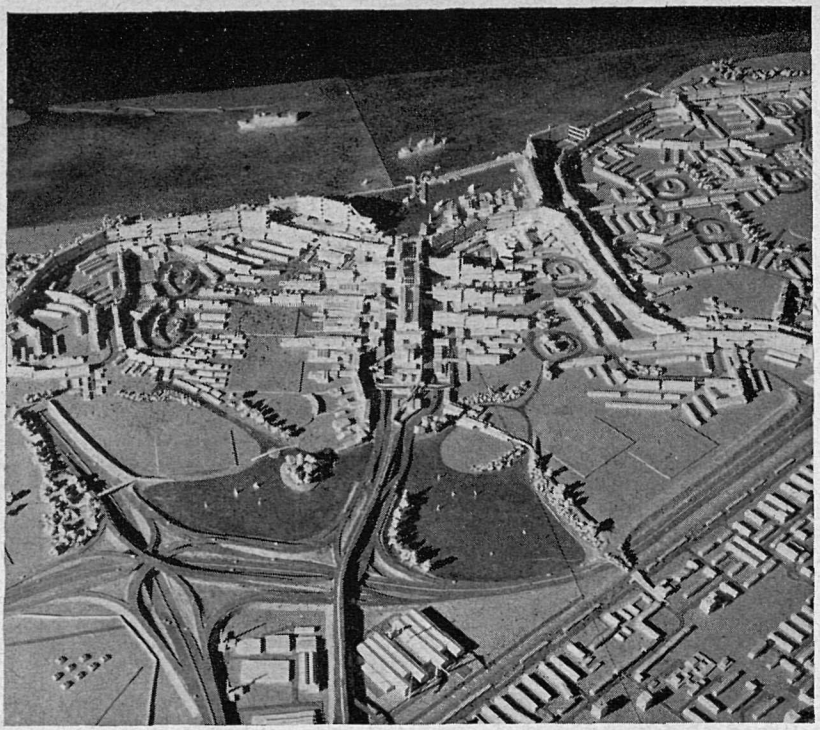
Getting Plans Accepted

Whilst all this planning was going on, we were also busy trying to set up some sort of administrative machinery. If the plans were to be accepted, many authorities would be involved; the G.L.C. (which had taken over from the L.C.C.), the boroughs of Bexley and Greenwich, in which Thamesmead lies, and also the executive councils, local professional and hospital committees, and of course the medical school here at Guy's. A medical planning liaison committee was set up under my chairmanship. Two years later, a more formal organisation became necessary, primarily representing the authorities with statutory health service responsibilities for Thamesmead (it should perhaps be made clear that Thamesmead is outside the Guy's catchment area). This was called the Joint Health Services Advisory Committee, and Dr. James Fairley, then S.A.M.O. of the South East Regional Hospital Board, became the first chairman.

Building Progress

The build-up of the town is now proceeding. By the beginning of 1971 the population was nearly 3,000. As would be expected, there is a high proportion of children, and no less than one in six of patients registered with the general practitioners is aged under five. An industrialised method of building is being used and a visit to the site is an exciting experience. The atmosphere is fascinating —the absence of vehicles and the scale of the "walk-ways" and open spaces are reminiscent of a Greek island town or an Italian city state.

The main building problem at Thamesmead is the height of the water table and the need to build everything on piles. The heavy costs involved have, among other factors, led to a modification of the original plan for a main centre with peripheral units. Instead it has been decided to concentrate medical care in two centres: the "Lakeside" health centre, which is due to be opened this year, and a main centre, which will house many laboratory and other resources which must be shared centrally, but which will not be built for four or five years. However, to cater for the growing population, a prefabricated centre, which is now in use, will be moved to various "growth points" within the town.



[*G.L.C. Photographic Unit*

Model of future town centre showing yacht marina and tunnel entrance (on left)

Medical Education

The initial impulse to participate in the Thamesmead project was an educational one, and this aspect has been high on my list of priorities from the outset. We were extremely fortunate that the Nuffield Foundation made a second generous grant to us at Guy's to support a general practice teaching unit until such time, not too distant we hope, when U.G.C. money will again flow towards the London Schools. With this help the Department of General Practice was set up under Dr. Peter Higgins, the first G.P. at Thamesmead. The new Department is firmly linked with the Department of Medicine.

Dr. Higgins believes that community medicine must not be thought of as "different" medicine, or "social" medicine, but as practice in different circumstances, still striving for the same standards.

In rethinking the medical curriculum plans have been suggested for more frequent visits and attachments to Thamesmead and other group practices. The main problem, of course, is to find time. My own present analysis suggests that we shall need (a) to reduce the size of our teaching groups; (b) to use our local hospitals more; and (c) I believe we should scrap the tail-end of present "firms", when things run down over the last few weeks, by reducing each "session" from thirteen to ten weeks. This would permit us to

increase the number of courses, and I would certainly recommend a ten-week course of community medicine when the new curriculum is organised.

Other Professions and Opportunities

The dental school at Guy's has been intensely interested in the Thamesmead project since its inception. Elsewhere in this issue Mr. David Johnston, the first dentist at Thamesmead, has described his plans and hopes. I would like to say a word about the opportunities which can be created at Thamesmead for training nurses, health visitors, medical secretaries, technicians and a whole host of "supplementary" professions which comprise our health service.

There is no need to belabour the shortage of skilled manpower in the N.H.S.; what is less well-known is the high rate of turnover. One solution is to provide training programmes which create job satisfaction, and I have been exploring the possibility that this can be done at Thamesmead. The idea is that, by indicating the potential interest of such vocations to local school children and by introducing such careers into the courses offered by the local polytechnics, it may be possible to re-interest the indigenous population in working in medical care. To this end we have had discussions with the staff at Woolwich Polytechnic which will be moved to Thamesmead within the next five or six years, and which may be sited alongside the main health centre.

Finally, I must mention two of the most exciting by-products of the project. As a direct result of our interest in the uses of modern computer technology for providing the communications of a commonly-based health service, the Department of Health awarded a large grant to the University of Essex to enable an extensive programme of research to be carried out. This is being directed by Dr. Keith Bowden, a computer scientist at Essex, and Dr. Michael Abrams of the Department of Medicine at Guy's. Much of the preliminary work is being done in a general practice at Harlow, but there is no doubt that, sooner or later, the Thamesmead services will gain much from the experiment.

The prospect of a large new community at Thamesmead also stimulated me to become interested in a new automated laboratory system for improved screening techniques. This was developed in the Department of Medicine and is now being produced by Vickers Ltd. Apart from its possible use at Thamesmead, it is gratifying to think that we have contributed to an export order worth several million pounds!

Conclusion

Despite setbacks and times of frustration, the Thamesmead project is moving steadily ahead towards an integrated education orientated medical care service. Guy's can, I believe, be well satisfied with the progress.

It would be impossible to acknowledge and thank everyone who contributed towards this success. I hope that I may be forgiven by all those people, inside and outside Guy's, whom I have not mentioned and who have done so much to make Thamesmead happen.

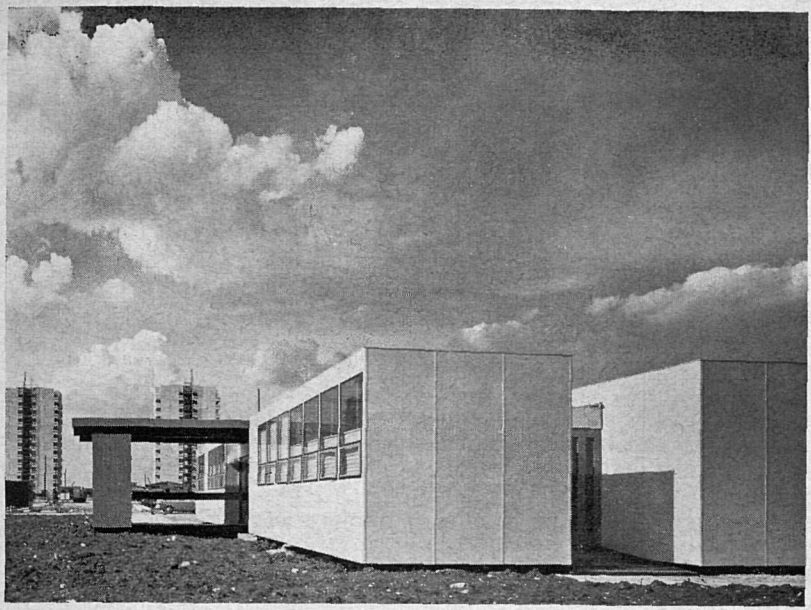
2. A Community Teaching Unit

P. M. Higgins

Guy's Hospital and the people of Southwark have shared the history of the past 200 years. Long before the N.H.S. formalised the growing separation between those who worked inside and those who worked outside its walls, the hospital ministered to the people round its doors, serving them as general practitioner, midwife, nurse, social worker, surgeon and physician. With few other services available, a sense of immediacy and involvement must then have characterised the relationships between hospital and community. The pressures upon the medical services arose directly out of the community's problems, and these were clear, stark and basic: poverty and destitution, poor housing and sanitation, epidemic disease. Faced with such pressures, doctors sought not only to provide care for the sick, but turned also their attention to prevention. Some engaged in what we now call Public Health, and a few indeed saw the need for political action to reform the conditions so many had to endure. Guy's was then truly a community teaching unit, and its students learnt the lessons of disease in close contact with a population that looked to the hospital as the source of virtually all its care.

Guy's has fortunately never lost that sense of involvement, but recent changes have made it increasingly difficult to comprehend and to respond to community problems with quite the same sense of urgency. One factor has been the need to serve a wider population as a referral centre, but the most important factors have been the growth of medical services in the community in isolation from the hospital and the increasing cost of hospital services. Patients no longer look, as in former times, to the hospital to satisfy all their needs, and at the same time the hospital has been under increasing pressure to use as intensively as possible its highly specialised and expensive resources. Not only is there a tendency, therefore, for it to concentrate on the special problems that it alone can deal with, but as the flow of work speeds up, it becomes more difficult to see the patient as an individual living in a family and a social setting for whom admission or attendance at out-patients is only part of his life. As a result of these changes, students have been cut off from a range of experience of health and disease and social conditions that would formerly have been freely available to them.

Moreover, now that the grosser community problems have been controlled, it seems less blameworthy for us to concentrate on the purely medical aspects, leaving social difficulties to those newer pro-



[*Richard Einzig*

Temporary Health Centre.

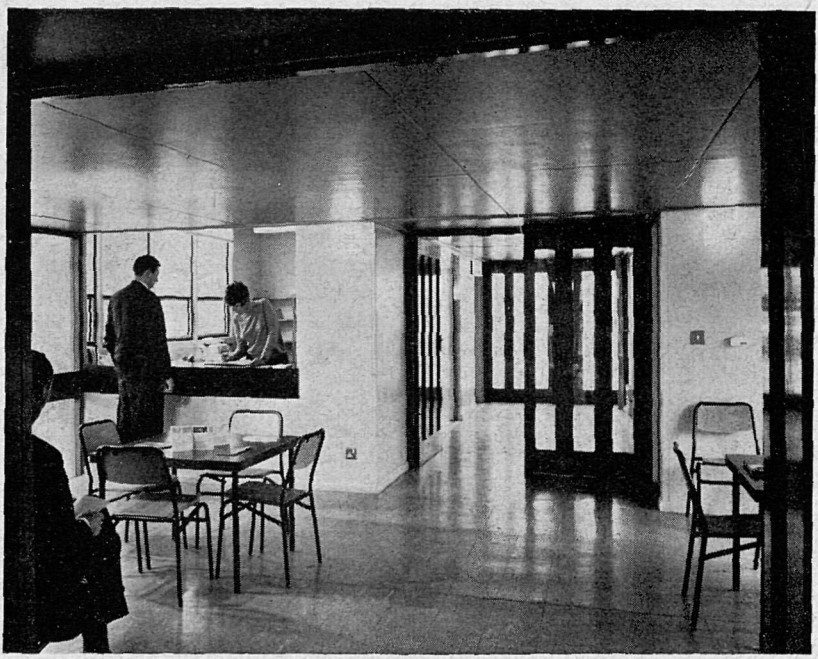
fessions eager to stake out their claims in this field. At the same time as medicine has itself become more institutionalised, kindly and well-meaning men have institutionalised charity and welfare and professionalised their application to "clients". No one need now be destitute (though many still live under wretched conditions): but problems still exist, and they are more subtle, less easy to define, less amenable to action than the old ones, and doctors cannot evade their consequences. The new problems arise out of the difficulties of living together in urban society, out of monotonous unrewarding labour, out of the relationships between the community and the lonely, the insecure and the old, out of the helplessness of the ordinary citizen in the face of organisations that make his decisions for him—where he may live, what kind of home he will have, what school his children will attend.

Every general practitioner as closely in contact with his population as the teaching hospitals used to be with their population, knows how many of his patients' problems have their roots in family and social circumstances and in maladjustment to society, and the demands it makes upon its frailer members. This is so even in a settled community; in a new community where none of the familiar

network of support and communications exist and where new relationships must be created and slowly fostered there is a bigger challenge still—but also a greater opportunity because no established patterns of behaviour and of services stand in the way of new methods. *If the load is great elsewhere, it is greater in the new community:* too great for the medical service to bear alone. Two choices face the general practitioner: to withdraw from the front line trenches and leave these to be manned by others—nurses, health visitors, social workers—or to sally out into the community to teach it to care itself for its vulnerable groups: to give and not just to receive. Medicine has an enormous contribution to make by offering a series of focal points around which the goodwill of the community might crystallise and what we might take as our aim is not "Community Care" with its connotations of cossetting and receiving, but "The Caring Community" with its sense of giving.

May it not be that this endeavour in the community will prove at least as valuable to society and as rewarding to medicine as the equally necessary work of the hospital? How indeed may we bring the two together again so that once more each becomes responsive to the needs of the other?

At Thamesmead we have a unique opportunity to create a teaching unit in the community, embracing both general practice and the



Temporary Health Centre—Interior.

hospital services, which will borrow from the Medical Officer of Health that sense of responsibility for a defined community that has till now been his alone. We have the chance to build up the medical services from the beginning and we have also the chance, as the new community grows, to strike a new balance between those services and the people they care for.

I have written in a previous article (Guy's Hospital *Gazette*, 10th May, 1969) about the contribution that general practice could make to undergraduate education. Such a teaching unit as is here described, straddling the boundary line between hospital and general practice, growing into something more than just the sum of its parts and seeking to create a new relationship with the community, could offer a new framework for the teaching of medicine. Here students might see the patient standing in his own setting, not temporarily horizontal in a hospital bed: see the factors that influence health and the perception of ill-health, see illness when it first presents and follow it to its end, whether this be at home or in hospital, watch the continuous care of the chronic sick and disabled, see the impact of illness on the family, become aware of the importance of prevention and health education. Here he may see asthma not as it presents in hospital, but as it exists in the community: how it may appear in the six-month-old baby or, for the first time, in the forty-year-old woman.

All this students may receive; what may they give? A very great deal: to the developing organisation criticism and help with monitoring its performance and consumer reaction: to patients' help and support with some of their problems. But above all, students, not yet fossilised into respectable professional men and women, could help develop relationships, new points of contact, between the organisation and the community, and it may indeed be possible, some time in the future to arrange for students, if they wish, to stay with families at Thamesmead and to help with the activities now being planned to cope with some of the vulnerable groups within the community.

With the help of our colleagues at Guy's, in the local hospital, and in public health, we hope to create at Thamesmead a community teaching unit that will not only offer first-rate medical care, making an essential contribution to the clinical training of the undergraduate, but will also take to their limit the consequences that flow from the total responsibility of the general practitioner for a defined population. In this we shall need to co-operate with our colleagues in other professions whose responsibilities overlap ours: in social work, teaching and nursing. In a sense we shall then be back where Guy's first started, beginning a new cycle to send fresh pulses through old vessels.

3. Community Dentistry

D. W. Johnston

Introduction

Community or public health dentistry is concerned with the prevention and control of dental disease and the promotion of dental health through organised community efforts. On the other hand, the general dental practitioner is primarily concerned with the treatment of dental disease in individuals. Ideally these elements should complement each other and although the National Health Service has led to some progress in this direction it has also had adverse effects, for instance, the movement of manpower from the school dental service into general practice. As a result the school dental service has had to concentrate its resources on providing curative treatment rather than on reducing the need. The concept of a community dental service is not therefore being fulfilled. It should be pointed out, however, that our limited resources have coped remarkably well with the demand for care. This may be seen from the growth in conservative dentistry under the NHS. In 1950 79 per cent of dental expenditure in the general dental services was for dentures, whereas in 1960 it was 27 per cent—a situation not wholly due to the imposition of patient charges during the decade!

Recent interest in the health centre as a mode of delivery of health services revitalizes the hope that the components of our Health Services can be brought together with a synergistic effect. But in this respect the dental services have lagged behind the medical services. Of the 218 new health centres opened in England and Wales from 1948 to 1970 about half provide school dental services and there are no more than 19 with general dental services. The particular opportunity of the new town situation, such as we have at Thamesmead, is that the general atmosphere of innovation may facilitate the acceptance of new ideas in health care delivery and that the complications of established practitioners in the area are considerably reduced.

The Main Problems

In planning a comprehensive dental service for Thamesmead we have had four main problems in mind.

(1) There is a wide gap between the nation's *needs* for dental care, as expressed by the high prevalence of dental disease and its *demands* as measured by the numbers of people attending regularly for dental treatment.

(2) Manpower resources in the United Kingdom are extremely limited; we have approximately one dentist to 4,000 of the population compared with, for example, one to 1,400 in Sweden and one to 2,000 in the U.S.A. The situation is not improving: the population is growing faster than recruitment to the profession, and increasing affluence may increase the demand for dental care. On the other hand, the new dental charges may have the opposite effect.

(3) The tripartite health service has led to fragmentation and duplication in the delivery of dental care and in a failure to adapt to changing conditions.
(4) The method of remuneration of dental practitioners is unsatisfactory. Payment by fee for item-of-service from a fixed schedule has proved frustrating for many dentists and may affect the quality of care.

The Thamesmead Proposals

Each of the three health centres planned for Thamesmead will have, it is hoped, ample provision for dental services. The temporary health centre now in use has a well-equipped dental surgery and a smaller room which can also be used for limited dental treatment. The permanent lakeside centre due to be opened at the end of 1971, will have three dental surgeries, a dental consulting room together with a laboratory, dark room, etc. Administrative accommodation and waiting rooms are shared with the medical side. A main health centre for the 48,000 people in the northern part of Thamesmead is still not beyond the stage of a feasibility study and the dental accommodation is not yet fixed. At the present time, planning is going ahead on the assumption that there will be at least one dentist per 4,000 of the population. It is recognised that, in order to work effectively, a dentist needs the use of more than one surgery, and extra surgeries may be provided for this purpose. Provision will also be made for dental auxiliaries.

It is intended that salaried dentists should provide a comprehensive integrated dental service from these centres—that is to say, the same dentists providing both general dental services on behalf of the executive councils and school dental services on behalf of the local authority. The problem of achieving adequate productivity in a salaried service is well-known: one of our first aims at Thamesmead will be to show that it can be solved. Teaching and research are the two other essential components of the programme. Undergraduates and graduates will be exposed to general practice and public health concepts in the health centres. There will be unique opportunities for epidemiological and operational research.

Progress so far

The dental services of Thamesmead have now been in operation for nearly eighteen months. Utilisation has been high. About a third of the current population have already been under treatment—a remarkably high figure in view of the fact that many of these people have been at Thamesmead for only a few months, and many came from communities where dental utilisation is notoriously low. The single dental surgery is already constantly in use, and it has been difficult to keep a proper balance between curative and preventive services. However, the situation should be more satisfactory when we move to the permanent centre. We have already started inspecting the school children, and a first impression suggests that the standard of dental fitness is well below that current in the south of England. A survey is now being undertaken in order to see whether or not this impression is correct. Dental students from Guy's have already started visiting the centre.

4. Hand Foot and Mouth Disease at Thamesmead

Monica Nath

Introduction

The hospital presents only a partial picture of illness in the community. From the mass of problems he sees the general practitioner refers only a proportion for hospital care and many conditions he may deal with himself from start to finish. Moreover, not all illness within the community is seen by a doctor : the Bermondsey survey (Butterfield 1968) showed that in an established community many people either put up with symptoms or seek advice and help from non-medical sources.

Hand Foot and Mouth Disease is a good example of a condition rarely encountered except in general practice. Three cases were seen at Thamesmead last summer and in addition to describing the features of a clinical syndrome unfamiliar to most students, this report includes the results of a survey in this new community where none of the familiar networks of communications might yet be expected to be functioning.

Thamesmead

Thamesmead is expected to house 60,000 Londoners on a hitherto undeveloped site between Woolwich and Erith. The work of planning the medical services was initiated by Dr. Robert Smith and Professor W. J. H. Butterfield from Guy's Hospital Medical School. A health centre to house four or five doctors, dentists and local authority staff will be ready next year and will serve 12,000 people moving in during the first two phases of the development. Meantime services are provided from a temporary health centre for the 3,000 or so people estimated to be in residence, 1,000 of whom were registered with the practice in July 1970. The health services are integrated, the staff being responsible both for general medical services and for the personal health services of the local authority. Their records therefore cover both the preventive and therapeutic services. An index of individual patients filed by age and sex and a separate index of all households filed by the number of the dwelling, and by the street, are kept.

Hand Foot and Mouth Disease

This condition, quite distinct from foot and mouth disease of animals which rarely infects man, was first recognised as a clinical entity, and its association with Coxsackie A virus infection established in Canada in 1957 (Robinson, Doane and Rhodes 1958) and in 1959 in this country (Alsop, Flewett and Foster 1960). Outbreaks and sporadic cases have since been reported all over the U.K. and America (Higgins 1969). (See figures 1 and 2).

Figure 1. Typical lesions on hand. [*H.M.S.O.*

As described in the literature, the disease is primarily a mild condition of young children 1–5 years old. Rarely adults (usually mothers of infected children) are affected. Cases are most frequently found in summer and autumn, and commonly the infection spreads within the family though not all show the clinical manifestations of the disease. There is a 3–6 day incubation period with slight constitutional symptoms. The child may be unwell 2–3 days before the skin eruptions appear, with a slight pyrexia (25–50 per cent). The skin lesions appear as a maculo-papular rash and progress to vesicle formation. They are found on the hands and feet and inside the mouth, and may also occur on the buttocks, thighs, shins or arms. Many infections are subclinical. Healing takes place in about seven days.

The causative agent has been established to be a Coxsackie virus usually type A16, though types A5 and A10 have been isolated from sporadic cases. Coxsackie viruses are picornaviruses and contain RNA. They occur most commonly in summer and autumn months and may be persistently excreted for several weeks after infection.

In 1960, 83 cases were described in Birmingham (Alsop, Flewett and Foster). The infection was mild and characterised by vesicular lesions in the mouth, on the hands and feet and occasionally on the buttocks. Coxsackie virus group A type 16 was isolated from vesicle fluid from the hand of one case. The cases included one adult but affected mainly the 0–4 years age-group. The lesions appeared as vesicles surrounded by a zone of erythema and shallow ulcers in the mouth. The duration of the illness was less than a week and there were no prodramata.

Other reports of sporadic cases from Bristol (Flewett *et al* 1963 and Clarke *et al* 1964) and in 1964 16 cases were reported in a

[*H.M.S.O.*

Figure 2. Typical lesions on foot.

Buckinghamshire Preparatory School with a slightly older age-group involved than that previously described. The typical features of vesicular lesions on the hands, feet, mouth and buttocks with general malaise and slight pyrexia were seen.

Case Reports

Three cases seen at Thamesmead this summer showed the following clinical features :

Case No. 1

Girl aged three years. Presented on 16th June with a 5-day history of vesicles on hands, feet, mouth and buttocks, malaise and pyrexia. The lesions were typical—small blisters with surrounding erythema. They were irritating and healed within 2–3 days of presentation. No other members of the family were affected and there were no known contacts.

Case No. 2

Girl aged 18 months. Presented on 22nd June with a 3-day history of general malaise, sore mouth, small vesicles on the palms and soles and a maculo-papular rash on the buttocks. The lesions were typical with small, shallow ulcers in the mouth. They were painful and irritating and healed in 5–7 days. No other member of the family was affected. The mother reported two other possible cases neither of which had been seen.

Case No. 3

Boy aged three years. Presented on 6th July with a 2-day history of a "nappy rash". On examination there was a vesicular rash in the nappy area and small, shallow ulcers in the mouth. The lesions were irritating and made feeding difficult and there

was some general malaise. The infection healed in 4–5 days. There were no known contacts.

Seven days later, this patient's sisters, aged six and nine years, developed shallow ulcers in the mouth, lasting 1–2 days.

Survey

An initial check was made on the clinical records of all children under five to see if any cases presenting either at the child health clinic or at the surgery had gone unrecognised. Particular attention was paid to babies presenting with nappy rash to see if any vesicles had been found. No further cases were discovered by this means.

A sample of the population was then selected by the following method. The household register was chosen as the sampling frame because this allowed the survey to be concentrated on those areas where cases were known to have occurred. The cards of all householders with one or more children under five were sorted out and one in five of the families in areas where cases had occurred and one in ten of all the remaining families were selected for interview.

Twenty-three families were selected in this way and interviewed. Only one further case of the condition was discovered—in fact, one of the cases reported by the mother of the children in case no. 2 (the second possible was also seen and was considered unlikely to have Hand Foot and Mouth Disease). This was a child of 17 months who contracted the disease about the beginning of July. The child developed a vesicular rash on the buttocks and ulcers in the mouth, with some malaise. No other member of the family was affected and the infection cleared up in seven days. The mother of this child had conferred with the mother of the child in case no. 2 and was content to treat her child at home without having recourse to medical care.

Discussion

Hand Foot and Mouth Disease is a usefully descriptive name for a condition that few students will have seen, and emphasises the main sites affected. That the rash may also be seen on the buttocks is not as well recognised, and the experience of the third child reported shows how important it is to be alert to the possibility that a vesicular "nappy rash" may be the presenting complaint.

The survey carried out indicated that even for a condition so upsetting to the child and potentially alarming for the parents not all patients present for medical help and suggests that informed lay advice may be a factor in limiting demand for medical care even in a new community.

Acknowledgment

This work was carried out during a six weeks' elective period at Thamesmead with the Department of General Practice at Guy's Hospital Medical School. I would like to thank Dr. P. M. Higgins (Head of the Department) for his help and encouragement.

References:

Higgins, P. G., *Health Trends*, Nov. 1969, 10.
Alsop, J., Flewett, F. H. and Foster, J. R., *Brit. Med. J.*, 1960, ii 1708.
Clarke, S. U. R., Morley, T. and Warin, R. P., *Brit. Med. J.*, 1964, i 58.
Flewett, T. H., Warin, R. P., and Clarke, S. U. R., *J. Clin. Path.*, 1963 **16**, 53.
Parsons, R., et al, *Brit. Med. J.*, 1960, i 1776.
Butterfield, W. J. H., Priorities in Medicine, Nuffield Provincial Hospitals Trust, 1968.

5. Thamesmead: Questions and Answers

M. P. Curwen

Where is Thamesmead?

Between Woolwich and Erith. It takes half an hour to get there by train from London Bridge.

How many people are living there now?

About 3,000.

When will it be finished?

It may take up to 15 years before the town is completed with a population of 60,000.

[*G.L.C. Photographic Unit*

Completed Linear Housing.

[*G.L.C. Photographic Unit*

High Density Housing by Lakeside.

What sort of people will live there?

At present almost all the families are from various London waiting lists and they rent their houses from the G.L.C. Within the next two or three years houses for sale will be built by private developers and it is intended that Thamesmead should ultimately contain a wide cross-section of the community.

What sort of jobs will they get?

It is planned to build new factories in Thamesmead. In the meantime there are opportunities in local industry. Communications to other parts of London will be improved by the new road system being built.

Who is responsible for the health services of Thamesmead?

As in the rest of the country these are the responsibility of the local authorities (in this case, the boroughs of Bexley and Greenwich), the executive councils, who look after the general medical and dental services and the local hospitals.

How does Guy's come into the picture?

See Professor Butterfield's article. Many of the doctors and dentists at Thamesmead will have teaching posts at Guy's and students have the chance to work alongside them in the Thamesmead health centres.

What medical services are available now at Thamesmead?

A temporary health centre (see photograph) was erected soon after the first families moved in. Two doctors now practice there in partnership and, with the help of a health visitor and a nurse, they provide clinic services including family planning, etc.

And what dental services?

There is one dental surgery. The two dentists working there provide normal NHS services and also look after school children.

When does the next health centre open?

Towards the end of this year. It will have much more space and facilities for teaching.

How can I go and see Thamesmead?

We hope to arrange coach trips at least once a term but anyone who wants to go on their own should get in touch with the Department of General Practice (15, St. Thomas Street) (ext. 570). There is plenty to see even if you wander around Thamesmead at the week-end when the health centre is shut.

THAMESMEAD WEEK

8th—12th March

Film

"Thamesmead 1970", in the Gordon Museum, follow by tape-slide programme of Community Health Project.

Monday, 8th March, 12.30 p.m.
Tuesday, 9th March, 4.30 p.m.
Wednesday, 10th March, 12.30 p.m.
Thursday, 11th March, 4.30 p.m.

Exhibition

Plans and drawings of Thamesmead.
Gordon Museum: open daily, 8th—12th March.

Visit to Thamesmead.

Coach leaves Great Maze Pond at 1.30 p.m.,
Wednesday,10th March.

Combined Round.

Thamesmead "Teach-in".
Chairman: Professor W. J. H. Butterfield.
Physics Theatre,
Friday, 12th March, 2 p.m.

Combined Round on Friday, 12th March.

THAMESMEAD TEACH-IN

at 2 p.m., Physics Theatre.

Chairman: Professor W. J. H. Butterfield.

Main Speakers :

Dr. J. Kerr Brown	Medical Officer of Health, Greenwich
Dr. Peter Higgins	Department of General Practice
Dr. David Morris	*Paediatrician, Woolwich Hospital Group*
Dr. W. J. Nicholson	Geriatrician, Woolwich Hospital Group
Dr. C. A. Smith	Psychiatrist, Woolwich Hospital Group
A student representative	

The teach-in will give students the opportunity to see what Thamesmead has to offer medical education and to say how they think a programme should be developed.

The main speakers are among those who will be responsible for providing health care to the people of Thamesmead in four main areas—child health, mental health, community health and health in old age. Some of their "opposite numbers" at Guy's will take part in the discussion but one of the main purposes is to hear the views of students.

NURSING SECTION

The Nurses and Their Future

A report in the *Nursing Times* of 4th February, 1970, made very interesting reading for those members of the Nursing Profession who have for some time had doubts about the efficacy of the Salmon Scheme.

The occasion was the opening of the new medical school at Nottingham University. The speaker was Sir George Pickering, who was making his oration in the presence of the Secretary of State for Social Services. He stated two very salient points. Firstly, that the morale of nursing will not be restored until the Ward Sister has the same prestige as a Physician or Surgeon; and secondly, that whereas in the U.S.A. nurses have transferred from wards to lecture theatres, in the United Kingdom certain members pace the corridors carrying sheafs of papers, while their over-worked colleagues in under-staffed wards struggle with the sick.

Sir George is, of course, completely correct in his assessment of the nursing situation in this country.

When the proposals of the Salmon Committee were first published, a great many nurses had marked reservations as to the eventual outcome. The pessimists amongst us have lived to see our worst fears materialize. Unfortunately, too few people took heed of the warnings in the initial instance, and ploughed their way happily deeper into the mire. Hence we are arriving at a situation from which it is impossible to retract, and in which the nursing standards in this country are going to be lowered irrevocably.

It is only to be expected that as with anything, there are advocates for the proposals. For instance, any person already appointed to a post of Chief Nursing Officer is unlikely to condemn the Scheme which gave her the opportunity of a higher salary and greater power. On the other hand, however, any of these people who proclaim that all is well in the profession, and that the new structure is a marked success in their area are guilty of one crime; namely, that they have failed to discuss the issue with their staff and establish the true feelings currently being experienced. It is pure delusion to imagine that all is well, for this is most certainly not the case.

The most senior members of the nursing profession cannot afford to remain aloof from their colleagues. There is marked unrest within the ranks. Shortly, these will have totally disbanded if action is not forthcoming. The Salmon Structure has been a gross mistake with insufficient planning. It has heralded the end of nursing in this country as the public have learnt to expect it. Unfortunately, our medical colleagues have only just begun to realise what the outcome will be. They are now in a state of amazement that such a situation could have arisen. Despite many warnings earlier on, it was not until they became personally affected that the impact was felt. Is it really too late, or have we still time to salvage what remains?

GUY'S ARTS AND CRAFTS EXHIBITION

FEBRUARY 1st—12th, 1971

"The exhibition shows a great variety of works of a high standard and with strong individual styles," was the first impression of Mr. Michael Noakes when visiting this year's Arts and Crafts Exhibition held in the Gordon Museum from February 1st—12th. Over 400 people viewed works exhibited by 51 entrants and many enjoyed the wine and cheese party traditionally held on the first night, when Mr. W. N. Mann opened the exhibition.

Mr. Noakes, a well-known artist and portrait painter, spared much time in coming to review the exhibition and select the prize-winning entries. Prizes of £5, £3 and £2 were awarded, respectively, to Dr. Neil Watson, "for water-colours of a most impressive standard"; to Mr. M. Malleson, "for most excellent skill in art and craftsmanship with silverware"; and to Dr. Mallinson, "for use of water-colours giving substance to the composition".

Due to the quantity of entries and limitations of space, we apologise for any disappointment in not hanging entries and for the short selection of comments by Mr. Noakes.

Of the various water-colour compositions, Mr. Noakes especially liked Dr. Mallinson's "Wawa, Pa., U.S.A.", Mr. C. Kinder's land and seascapes and Dr. Neil Watson's "good selection of water-colours, of which the 'Fisherman of Gozo' were encouraging amongst such a predominance of architectural studies".

A new section of photographic studies and poetry aroused interest and a number of caricatures by Nick Astbury and an "apology to Giles" by Chris Franks aroused much humour.

As in previous years, a large number of oil-paintings were received, of which the landscapes by Mr. W. N. Mann showed "a good feel for atmosphere", the trees in "Greenwich Park", by Dr. John Rake, showed a very individual style and one could sense the enjoyment of Mr. Maloney in making the waves spray around the lighthouse in his seascape.

Individual styles dominated the abstract oil-paintings, including Miss D. A. Baker's "good feeling for the texture of the medium and interesting colour schemes in 'Metamorphosis'", Miss F. Phillips's "good colour sense, not over-emphasised as so often seen now" and Miss L. Hutcheon's "use of thin paint with vitality and strong colour with restraint".

Line drawings by Mr. M. Adinolfi "showed assurance and a good eye for pattern"; pen and ink studies by Paul Darton "expressed violence in movement with economy" and those by Wilson Harvey showed "skilful selection of only part of a composition to portray and project the atmosphere". Pen and ink drawings by Miss R. Ede (previous Secretary of the Arts Society and notable helper with this

year's exhibition) showed "nice economic use of line and interest in fashion".

The "Kids' Corner" was a new addition this year and much artistic talent was shown by children of Caleb and Diplock wards and Evelina Hospital. Michael O'Rourke's "Moonlanding" was "both effective and topical" and just one in a "delightful selection of works".

The Crafts section of the exhibition was of a very high standard and included Mr. M. Malleson's hand-made silverware of "Immensely impressive craftsmanship learnt over the years", Joyce Hoskin's skilful needlework and Miss J. Fusniak's "rich and forceful use of different materials" in her Oriental peacock collage. Miss G. Redding's stoneware bowl "with parsimonious reduced glaze was most pleasing", as were the glazes on both Miss H. Pels' and Miss M. Hooley's pottery. Silver rings by Mr. M. Gross and a silver pendant by Mrs. Brown were unusual items of jewellery. Sculptures, wood-carvings and mobile works, especially Mr. Goldsmith's copper tubing composition, were most impressive. Mr. B. Babic's design, specification and working model of an adjustable spanner and vice were not only technically ingenious but of great interest to many visitors, including Mr. Noakes.

NOTICES

GUY'S HOSPITAL STUDENTS' CLUB

The Election for the Student President for the year 1971-72 will be held on Thursday, 11th March, 1971.

Nominations must be made by 5.00 p.m. on Thursday, 4th March, 1971.

A notice giving details of the procedure for making nomination and for the Election is posted in the Entrance Hall of the Medical School, the Dental Department and the Students' Club, and in the Colonnade. The Nomination List is posted in the Entrance Hall of the Students' Club.

ANNUAL GENERAL MEETING

Notice is hereby given that the Annual General Meeting of the Students' Club will be held in the Physiology Lecture Theatre in the Medical School on Tuesday, 16th March, 1971, at 12.15 p.m.

S. A. R. COOKE,
Hon. Secretary,
Guy's Hospital Students' Club.

AGENDA

1. To read, confirm and sign the Minutes of the last Annual General Meeting, held on 8th May, 1970.
2. Matters arising from the Minutes.
3. To receive a report from the Retiring Student President.
4. To elect the following Officers for the year 1971-72:
   (a) A President of the Students' Club.
   (b) A Senior Secretary.
   (c) A Senior Treasurer.
   (d) A Student Secretary from among the student representatives on the Council.
   (e) A Student Treasurer from among the student representatives on the Council.
5. To report the result of the election for the Student President for the year 1971-72.
6. To receive the Accounts of the Students' Club and of the Bar for the year 1969-70.
7. Any other business.

SPORT

This week saw the retirement of Tim Higenbottam as Sports' Editor of the *Gazette* after 18 months good service. Tim took over from Ian Morris and managed not just to keep up the high standard of the sports section, but through the excellent editorials to arouse considerable interest in the current rôle of hospital sports.

Not only through his writings in the *Gazette*, but through a great deal of hard work directly, he has made a noteworthy contribution to sports activities at Guy's. His industry has been directed, in particular, towards the rugby club where, through his encouragement he has managed to maintain the enthusiasm of a substantial number of young rugby players at a time when Guy's rugby has not been at its strongest. Let us take this opportunity to thank him for his contribution to Guy's sports and wish him success for the future.

We welcome Ashley Royston as the new Sports' Editor.

RUGBY

HOSPITAL CUP SEMI-FINAL
GUY'S v. ST. BARTHOLOMEW'S

Result: Won 13—5.

Guy's, who have reached the final of the Hospitals' Cup competition for the last three years, again won a place in the final after a magnificent showing against Bart's. This victory was indeed sweet to a Guy's side, many of whom must recall with bitterness the last two Cup encounters with Bart's.

Right from the kick-off, Bart's found themselves under pressure from the Guy's pack, who rucked intelligently and were constantly aware of the importance of tidy possession. Guy's had the first opportunity to score when the referee penalised the over-eager Bart's back row for breaking early. Ross failed with this penalty, a kick which on a dry day would certainly have presented him with no difficulty. Both sides had several penalty chances in the early part of the game but neither seemed to have a kicker for the occasion.

The first blood went to Bart's with a fine try under the posts after a double scissor movement which left the Guy's defence wide open.

Just before half-time Croft, the Guy's scrum-half, injured his right leg and spent the remainder of the match as an auxiliary full-back, being barely able to walk.

Restarting after the interval with 14 fit men and a 5-point deficit, only the most optimistic of the Guy's supporters could have seriously entertained thoughts of victory. However, Guy's seven-man pack rose to the occasion so magnificently that it was Bart's who were soon in difficulties. Thorburn, too, deputising for Croft, played an inspired game; indeed, from his crisp service came Guy's first points, after Novak burst down the middle to put Campbell over in the corner. Damford was unlucky with the conversion, missing by only a couple of feet. From this point onwards the Guy's team never looked back. In the forwards, Neville was outstanding, being the instigator of repeated forward rushes. The three-quarters all played well, Novak in particular having a splendid game.

The referee awarded Guy's a penalty try after Novak beat the full-back and was obstructed whilst chasing his own short kick to the line. Damford converted.

Guy's last try came after Thorburn sent Novak away down the blind side; Novak, using his size and speed to the full, crashed through his opposite number to score in the corner. Damford converted, the ball lingering a moment on the crossbar before finally going over.

Team: M. Damford, R. Barrough, J. R. Ross, A. Campbell, M. J. Novak, D. Jones, C. Croft, G. Evans, T. Gibson, D. Stuart, R. Burt, C. G. Neville, A. Fallowfield, I. Baker, C. W. Thorburn.

The final of the Hospitals' Cup will be at Richmond on Wednesday, 3rd March, against either Westminster or St. Mary's Hospital.

FOOTBALL

HOSPITALS LEAGUE
1st XI v. CHARING CROSS

Played at H.O.P. on Wednesday, 10th February.
Result: Won 7—2.

Guy's, without Edwards and McClure, faced a Charing Cross side similarly weakened by the absence of their United Hospitals' players, and were soon a goal to the good when Coley scored direct from a corner. Despite this early lead, Guy's failed to dominate, and Charing Cross equalised following weak defensive covering. It was not until a few minutes before half-time that Winter scored from a narrow angle, and when Holliday headed home barely a minute later, Guy's were rather flattered by their 3—1 advantage.

However, Winter scored again immediately after the interval, and from then on Guy's settled down to play some neat football, and further goals by Holliday, Winter and Coley made Guy's comfortable winners. Despite the size of the win, this was in some ways an indifferent performance, and only Walker, Coley and Holliday played really well.

Team: T. Walker, J. Grace, D. MacConnell, M. Drew, P. Coley, A. Godman, N. Harradine, H. Holliday, M. Winter, C. Baker, G. Barker.

HOCKEY

UNIVERSITY OF LONDON CUP

Result: Guy's 1, Imperial College 0.

Guy's were without Crafts due to pressure of work, but still managed to win a game in which short corners against were too numerous to count and John Cottingham saved a penalty stroke.

For the first ten minutes, it really looked as if the team might be playing hockey, but once Bob Fell had converted a penalty stroke, the standard lapsed in typical fashion. Robert Clark was unlucky not to be awarded a goal when the ball flew off the handle of his stick into the net, but otherwise, the forwards never featured.

Some very cool-headed play by Richard Fitton and Nick Mathews, and repeated good stops by Cottingham, enabled Guy's to come through to the final. This will be held some time in March. Guy's are also in the semi-final of the Hospitals Cup with a good chance of reaching the final. The team are hoping that the hitherto invisible Supporters' Club will suddenly come to life for these two finals.

Team: R. Burns, R. Fell, R. Clark, T. Cottingham, J. Walker, N. Mathews, R. Fitton, P. Nicol, P. Calvert, J. Shutes, P. Wilmer.

R.W.B.

WATER POLO

UNIVERSITY OF LONDON LEAGUE
GUY'S I v. IMPERIAL COLLEGE I

Lost 1—7.

The match was disappointing for Guy's, who truly suffered from inadequate practice and lack of fitness. The backbone of the team consisted of Bevis, Challacombe and Northcott—the few original first team players still remaining at Guy's. Sands added strength. Tony Winder admirably came along and played well in goal for the second half. Bowering shuttled to and fro between goal in the first half and mid-field in the second half, doing the best that he possibly could. Tony Attwood and some charming female polo fans added grateful support at the bath side. The Imperial College side were faster than the Guy's side and made many crafty breaks which made them difficult to mark. Their exceedingly tight marking also contributed to our defeat. Guy's played better in the second half at the beginning of which we were 5—0 down and only thanks to Bevis in the last quarter, the final score was 1—7 to the opposition.

Team: C. Bevis, S. Challacombe, G. Northcott, T. Sands, J. Clark, R. Bowering, M. Rowlands and A. Winder.

R. J. B. Bowering

BOAT CLUB

LONDON ROWING CLUB REGATTA

Saturday, 6th February

For their second outing this year Guy's "B" took to the water with a borrowed man against Pembroke and Churchill Colleges, Cambridge. Churchill won easily, leaving Guy's rowing a style of their own to lose by one length to Pembroke.

Guy's "A" met Pembroke and Emanuel School in their first round and, after a powerful start Emanuel and Guy's fought for the clear water. Pembroke receded into the distance and Guy's settled down to beat Emanuel by $1\frac{1}{4}$ lengths. Meanwhile Churchill beat Imperial College by one length whilst Chelsea College struggled home with a crab-catching bowman.

The freshers under the guise of Guy's "C" although at Chiswick they are known as "Guy's wreckers", were drawn against Bart's who sported a very experienced stern four. However, what the freshers lacked in experience they showed in determination and, ably coxed, they trailed Bart's one length down. As the crews drew near the boathouse, and the cheer of a lonely supporter drifted across the water, Guy's dramatically drew up half-a-length, and with a terrific effort sprinted to finish a mere 2 feet down!

The "A" crew next boated for their semi-final against St. Bart's and 1st and 3rd Trinity, who had previously beaten the London, although this turned out to be an uneventful paddle, Guy's winning easily. Declining to row the final immediately, the crew returned to the I.C. boathouse.

In the final, Churchill paddled perfectly despite their pink blades, and Guy's had to be content to lose by two lengths to the heavier crew. However, altogether it was a promising start to the season—an empiricism for the future.

"A" Crew: Bow, H. Fuller; 2, D. Barker; 3, R. Newton; 4, G. Moulding; 5, C. Price; 6, P. Stevenson-Moore; 7, A. Batch; Stroke, M. J. Gleeson; Cox, D. Evans.

"B" Crew: Bow, G. Bergman; 2, E. Fox; 3, P. Read; 4, T. Barnes; 5, J. Monson; 6, J. Ogle; 7, B. Boyle; Stroke, N. Hopkins; Cox, R. Ashman.

"C" Crew: Bow, M. Browne; 2, D. Carman; 3, J. Squire; 4, G. Robbins; 5, L. Rabb; 6, K. Freeman; 7, S. Large; Stroke, D. M. Curtin; Cox, G. Brown.

SQUASH RACKETS

SINGLES TOURNAMENT, 1970-71

This year there was a good entry for the singles competition, 42 people taking part, including one female.

With a little gentle persuasion the bye round and first round were completed before Christmas. Martin Damford produced the first major upset by beating Chris Ellis, the league secretary, in the bye round, and in the first round Edward Evans had considerable difficulty in coping with some accurate drop shots from Phil Boyce and was quite fortunate to win after a long close match. The other seven "seeds" won their games comfortably.

The competition proceeded this term and the second round has now been completed. It produced one upset when John Lewis, fresh back from a skiing holiday, was beaten by Chris Mackenzie. Chris, in his first year at Guy's has improved considerably and, if he maintains this rate of progress, should be a great asset to Guy's squash in years to come.

2nd Round Results (seedings in brackets): J. Owen (1), beat J. Ogle; A. Edwards (8), beat R. Paisey; C. Mackenzie, beat J. Lewis (4); E. Evans (5), beat D. Evans; P. Calvert (3) beat I. Harrison; C. Langdon (6), beat R. Yetton; J. Mackay (7), beat C. Gilbert; T. Reynolds (2) w/o J. Ramsey.

Doubles Squash at Guy's

It has been decided to hold the first Guy's squash doubles tournament in March and April. Watch the squash notice board, outside the students' bar, for details.

Matches :

With John Lewis away skiing and Jerry Owen sunning himself in East Africa, we were somewhat weakened for the first few matches in January. Despite this, results were reasonable. We finished January with a fine win over Brighton, thus completing the first "double" over the club for many years, if not the first ever.

Results:

2nd V	v.	C.E.G.B.,	Lost 1—4
1st V	v.	Old Hurstjohnians,	Lost 1—4
1st V	v.	Old Paulines,	Lost 3—2
1st V	v.	Old Framlinghamians,	Won 3—2
1st V	v.	Middleton,	Lost 1—4
1st V	v.	Brighton,	Won 3—2

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL

Applications are invited for the post of **Registrar** in the Department of Psychological Medicine commencing 8th March or as soon as possible thereafter until 30th September, 1971. Applications together with the names of two referees should be sent to the Superintendent, Guy's Hospital, S.E.1, or Tel: No. 01-407 7600 Ext. 318, not later than **5th March, 1971.**

PASS LIST

THE CHARTERED SOCIETY OF PHYSIOTHERAPY
FINAL EXAMINATION
February 1971

Miss N. C. Armstrong
Miss A. M. S. Boulter
Miss J. E. Carey
Mrs. P. M. Currier (née Williams)
Miss J. S. Mansfield-Brown
Miss I. Martindale
Miss P. A. Redfern
Miss C. M. Wakefield
Miss D. S. Willis

PERSONAL

HOUSE TO LET—54 Dunoon Road, Forest Hill, S.E.23. Comprising two reception, kitchenette, cloakroom with W.C. four bedrooms, bathroom and separate W.C. garage, central heating throughout. Rent £520 p.a. and rates (at present £93 p.a.) Enquiries to Mr. Loomes, Counting House, Guy's Hospital (Phone 407-3662 Ext. 60).

CHANGE OF ADDRESS

Professor and Mrs. W. E. Herbert, Half Acre, 58, Kingswood Firs, Grayshott, Hindhead, Surrey. Tel: Hindhead 4563 (now on STD).

We would like to remind our readers that all copy for inclusion in the "Gazette" must be received eight days before publication date.

Copy may be sent to us c/o The Front Lodge, Guy's Hospital or left in the "Gazette" pigeon-hole in the East Wing.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, please indicate whether or not this should be published.

Personal notices one shilling per word (pre-paid) (minimum £1. 1s. 0d.). Non-subscribers will pay £1. 1s. 0d. (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

EDITORS N. D. S. BAX and A. M. TURNER
NEWS EDITORS R. M. DARLING and J. L. LEWIS
SPORTS CORRESPONDENT A. M. ROYSTON
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TEN PENCE VOLUME 85 NUMBER 2156

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Doctors and the G.M.C.

Gracious goodness, what a fortnight it has been for doctors! They have been strung up in public in a way that we no longer tolerate for other people when it is suspected they have behaved anti-socially. Both doctors who were called so publicly to appear before the General Medical Council this week had their cases laid open to press and breakfast table debate before their cases had been heard by the Council.

Now it was only recently decided that cases should be organised for presentation in law courts before an unrestrained press is permitted to carry the story. The safeguard is a good one and should be applied in cases where doctors are brought before their own disciplinary body by any member of the public. Naturally the findings of the Council must be published and the process leading up to its decision must be subject to public scrutiny, but there is a great deal of difference between the press coverage of a vindicated doctor and that of a doctor accused of betraying his profession. His reputation, rightly so precious to him, suffers at the mercy of front page tabloid headlines, no matter what the final reasoned outcome.

Coverage by the self-named media is recognised to have a persuasive effect on those that are to judge the issue, and secondly the opprobrium attached to a doctor, brought before the Council to answer charges, stays in the minds of his patients, who consider that whether proved guilty or not, there must have been something imperfect to spark off all the upset. In Australia, details of their General

Medical Body's cases are not published until a doctor has been cleared or found guilty of serious professional misconduct. The same should apply in this country.

Noise

At the present time the Senior 2nd M.B. students are sitting the 2nd M.B. examination. We wish them luck and an element of this they will need. The examination is taken in laboratories, the students sitting on stools of questionable safety which in turn are on a floor of uncertain flatness. Undoubtedly as in past years a noise that befits major architectural alterations may well be emanating from right outside the laboratories' windows.

It is not just examinations that suffer interference by noise. One current disease sweeping through the early morning lectures is to arrive late and see how many other students can be inconvenienced and note pads knocked to the floor before the lecturer is able to continue. It is not as if the lecture theatres are comfortable places to take notes anyway.

Some time ago it was easy to find a dark corner in the Wills' library where one could read in peace. It still is easy to find a dark corner, but no longer is the library the sanctuary it was. It has now taken on the function of a gossip corner and recipe exchange bureau. The pandemonium caused by rattling pipes, strip-lighting going into failure, people wanting somewhere else to continue their conversation after the Spit is no longer serving coffee, and the electronic rumble of duplicating machines is far from an environment conducive to study. In addition to the present noisiness of the Wills' library it is at times becoming increasingly difficult to find a seat even one of the broken ones. This may resolve when the 2nd M.B. students have their Easter holidays.

The noise is, on the whole, not made deliberately but made quite unconsciously. It may be that the latter condition is the worse of the two as the perpetrators lack insight. Nevertheless, its nuisance value is great. It may be made unconsciously but it is quite unnecessary.

GUY'S DIARY

MARCH

18	Th	1.00 Clinical Lecture. Dr. A. STEVENS. "Old Ones, New Ones, Loved Ones, Neglected Ones."
19	F	1.00 Clinical Lecture. Dr. SCOTT. "Pain in the Chest." 2.15 Combined Round. Mr. KINDER. "A Case of Papillary Neurosis."
22	M	1.00 Clinical Lecture. Mr. TOMKINSON. "Infertility Problems".
23	Tu	1.00 Clinical Lecture. Mr. BLACKBURN.
25	Th	1.00 Clinical Lecture. Mr. ROSS. "Coronary Artery Disease."
26	F	1.00 Clinical Lecture. Dr. CHAMBERLAIN. "The Causes and Consequences of Hypoxia".

NEWS IN BRIEF

Progressive Patient Care

An experimental scheme for patient care is shortly to come into operation at St. Olave's Hospital, Rotherhithe. The aim of the experiment is primarily to tailor nursing care to the needs of the individual patient, and in addition it is hoped to increase the rate of throughput of patients, and provide an overall increase in the nurse-patient ratio.

There will be three grades of nursing care : "heavy dependency", "intermediate" and "homeward-bound". The first will be an intensive-care unit, with separate medical and surgical areas, including a coronary care unit. The two wards will be adjacent to the operating theatres, and there will be a recovery room attached to the surgical unit. The wards will contain both male and female patients.

The "intermediate" areas will be equivalent to present general medical and surgical wards, although there will be no more allotting of wards or beds to particular specialities, e.g. surgical wards will contain both general surgical and gynaecological patients.

The Homeward-Bound unit will contain both medical and surgical patients who are nearly ready to go home, and require no medical or nursing care, e.g. they will make their own beds. As a result the unit will need very few nurses : at night there will be one nurse for 50 patients.

Patients will be transferred from one area to another as their condition improves (or deteriorates).

In addition, an Investigation Unit will be set up, to be open only on weekdays, to which patients will be admitted for investigations. It is intended that patients will be admitted early in the week, so that the results of their investigations are available by the end of the week, at which time they can either be discharged or transferred to a ward. A similar degree of self-care will be required as for the Homeward-Bound Unit, and the degree of nursing care will be the same.

As a result of the scheme, the number of beds at the hospital will be reduced by 30 or 40 to 230, and the number of nurses will remain constant, thereby increasing the overall nurse-patient ratio. If it is successful, the project could provide a model for other teaching hospitals.

It is hoped that the scheme will come into operation in October, 1971.

The Student Club Book Exchange

The Student Club Book Exchange, which is intended to provide a means whereby students can buy secondhand medical and dental books, and sell their own, has had a rather chequered career. It

came under new management, however, in July, 1970, at which time it was found to owe £383 to students whose books it had sold, and yet had only £100 in the bank. There were about £60-worth of out-of-date and thus valueless cheques in the till. The new proprietors hope to have broken even by the end of March—this has been achieved by reorganisation and an intensive advertising campaign, which includes letters to all freshers, regular opening hours (1—2 p.m. every weekday) and an attempt to provide an advisory service. Present turnover rate is about five books per day and about £600 p.a., which, with a 10 per cent commission, will provide the Students' Union with £60 p.a.

One problem which the Book Exchange has to face is the disappearance of about 50 books a year, which might prove interesting to those who think that medical and dental students, and therefore presumably doctors and dentists, are more honest than average. As you slip that Gray's Anatomy under your coat, aspiring doctor, you might remember that you are stealing directly from a fellow student who is just as impoverished as you are, and not from some wealthy establishment "that can afford it".

Nurses' Home Rebuilding

Phase VI of the Nurses' Home upgrading programme has recently started. The first five phases included the renovation of all student bedrooms in the Henriette Raphael Nurses' Home, and the amalgamation and re-housing of the Schools of Nursing, Physiotherapy and Radiography with Radiotherapy. The sixth and final phase, which is the most complex, will provide a new kitchen, an additional dining room, greatly increased locker and changing accommodation for non-resident nursing and catering staff, and a common room for students of the Preliminary Training School. The new kitchen will be on a new first floor, directly above the present kitchen, which will be replaced by a new servery supplying both the present dining room and the new West dining room. The basement, including the swimming pool, will provide changing and locker accommodation. While work is in progress, temporary catering facilities are being provided, making use of the existing Staff Nurses' and Nurses' Sitting and T.V. rooms, as well as two temporary buildings. The scheme will take two years to complete, and cost about £350,000.

Until the opening of the proposed new swimming pool under the Greenwood Auditorium to the east of the Tower, an arrangement has been made for nurses to use the Mile End Road baths, on Monday evenings between 7 and 8 p.m.

Research News

We are hoping to print a series of articles on the many research projects which are in progress in the hospital and medical school. The first of these is based on the work of Dr. P. Folb in the Department of Clinical Pharmacology.

In recent years a relatively new and large-scale problem has emerged in the field of infectious disease—that of "opportunistic infection". The word opportunistic derives originally from Italian

mps

medical protection society est. 1892

Students!
Arrange membership now.
Full benefit immediately
you qualify.
Pay later at no extra cost.

Over 50,000 members enjoy

- unlimited advice
- unlimited legal aid
- unlimited indemnity

Full details from
Secretary:
Dr. H.A. Constable, Head Office
50 Hallam Street, London, W1N 6DE
Telephone: 01-580 9241
or
Regional Secretary:
Dr. P.G.T. Ford, Regional Office,
30 Park Square, Leeds 1
Telephone: 0532 42115-6

politics, and it was probably brought into the English language by Lord Granville[1], who defined its meaning as "adapting yourself to those circumstances which are most fitted to getting you into power and to maintaining you there". Opportunistic infections are caused by organisms which are normally not pathogenic, but which cause disease and even death when the normal defence mechanisms are undermined by other disease processes or by intensive cytotoxic or steroid drug therapy.

Fungal infections are of special importance in this context. In the fields of transplantation surgery, and of cancer, reticulosis and leukaemia chemotherapy, disseminated infection with fungi such as Candida and Aspergillus has become an ever-increasing hazard in recent years. Almost invariably disseminated infection with such organisms has a fatal outcome. The reasons why such relatively harmless and ubiquitous organisms should achieve such pathogenicity in the predisposed subject have been hitherto unexplained.

An attempt has been made recently at Guy's to examine the immunological mechanisms which might predispose to such infection[2]. Taking Candida infection as a model, immunity to the organism of normal subjects was compared with the changes in immunity to the organisms which occurred in patients receiving immuno-suppressive therapy following renal transplantation in order to prevent homograft rejection, in patients receiving high-dosage steroid therapy for various chronic disorders such as bronchial asthma and ulcerative colitis, and in a small group of patients who received cytotoxic therapy with cyclophosphamide for chronic progressive renal disease.

It was demonstrated that the fundamental disorder of immunity which occurred in these drug-treated patients compared with normal subjects was the development of defective cellular immunity to the Candida organism. Humoral immunity (i.e. circulating antibodies) was not affected[3]. The inference was that it is cellular immunity that is of critical importance in the normal resistance to Candida (and probably certain other fungi, e.g. Aspergillus), and that it is this aspect of resistance that is particularly undermined by high-dosage, long-term steroid, immunosuppressive and cytotoxic drug therapy.

Turk[4] has stated that from the points of view of comparative pathology and of evolutionary development, cellular immune mechanisms are probably more primitive than humoral defence mechanisms. Man, it seems, has been exposed to Candida organisms for much of his evolutionary development. Perhaps it is those potentially pathogenic organisms to which man has been exposed from early in his evolutionary existence which are handled primarily by cellular immune mechanisms.

References :

[1]Granville, Lord G. (1882). Letter: *The Times*, London.
[2]Folb, P. I. (1970). M.D. Thesis. University of Cape Town.
[3]Folb, P. I. and Trounce, J. R. (1970). *Lancet*, **ii**, 1,118.
[4]Turk, J. L. (1969). Immunology in Clinical Medicine. Heinemann, London.

OBITUARY

PROFESSOR S. J. DE NAVASQUEZ

Sigiberto De Navasquez, Emeritus Professor of Morbid Anatomy in London University, died suddenly from coronary thrombosis at his home on 21st February. His loss, so soon after his retirement, is the more painful because he had recovered so well from his recent illness. All of us will wish to express our deepest sympathy to his widow and brothers.

Sigiberto was descended from a distinguished Spanish-Italian family, but was born at Sao Paolo, Brazil, in 1905, where his father was then living. He came to Britain at the age of two and was educated privately in London: in 1921 he entered Guy's as a student at the early age of 16. He qualified with the Conjoint Diploma in 1927, and M.B., B.S. (London) in 1928, and proceeded to the M.D. degree in 1934. His talents in histopathology and bacteriology while still a student led him, soon after qualifying, to spend a period at the London School of Hygiene and Tropical Medicine, where he obtained the Diploma in Tropical Medicine and Hygiene in 1929. He returned to Guy's in 1929 as Assistant Bacteriologist. In 1932 he was appointed Griffiths Demonstrator in Pathology and Lecturer five years later. He volunteered for military service early in the Second World War, serving in the R.A.M.C. as a Specialist Pathologist and reaching the rank of Major. His tour of duty took him to Northern Ireland, to Normandy in 1944 and on to Germany. After the war he returned to Guy's and was appointed Reader in Pathology in 1946. In 1965 the title of Professor of Morbid Anatomy was conferred on him by London University, and the School appointed him Curator of the Gordon Museum. He succeeded the late Professor G. W. de P. Nicholson as Clinical Microscopist to Guy's Hospital in 1949, a service post that he held for 21 years until his retirement in 1970. In all he was associated with Guy's for a span of 50 years.

Generations of doctors who have qualified from Guy's owe Sigiberto a tremendous debt for an education in pathology and common sense. This common sense, his incisiveness and refusal to be diverted by trivia, were of inestimable value to the hospital, while his natural courtesy and the immense pains he took with professional or personal problems endeared him both to students and staff. He would have wished to be remembered as a hedonist and humanist, but his kindness, generosity and thoughtfulness for others took complete precedence over his pleasures. He was a most modest man, demanding little for himself and giving far more than he ever took. He never used his hereditary title of Count and was not too happy to be called Professor. His modesty is further revealed by finding that, except as a student, he managed never to be photographed at Guy's. Long-

winded committees were an anathema to him; he could not abide their unproductivity. His method was to be well-organised, never to dither and, above all, to avoid paper. In this way, in spite of his hospital and teaching commitments, he found the time for research and to make a number of substantial improvements to the Gordon Museum during his tenure of the Curatorship. As successor to Nicholson, both in duties and philosophy, his death seems to conclude an epoch —in truth it marks the end of a dynasty.

Perhaps it is not really recognised here how much Sigiberto contributed to experimental pathology from the mid-thirties to the early sixties. Indeed, American pathologists of an older generation regarded him primarily as an experimental renal pathologist. He systematically investigated acute and chronic pyelonephritis and the routes of infection involved. From this work stemmed the realisation that haematogenous dissemination of bacteria is an important cause of the disease. For many years he collaborated with the late Professor R. H. Gorrill in this research. He also published papers on bilateral cortical necrosis of the kidneys, amyloid neuropathy, bacterial endocarditis, pulmonary hypertension, malignant hypertension, syphilis, tuberculosis, lipoid pneumonia and a variety of other pathological topics. In addition, some 30 years ago, he wrote a most thoughtful paper on the pathogenesis of the "transfusion kidney". In the early stages of this work he conducted hair-raising experiments on himself on the renal clearance of haemoglobin.

Throughout his life Sigiberto was a connoisseur of the fine arts. Apart from an encyclopaedic knowledge of painters and painting, he was also deeply interested in architecture, sculpture, silver and glass, where design and shape count for more than decoration and colour. There were few museums whose contents he did not know intimately, and he had a remarkable memory for where everything was. He had intended when he retired to take a Fine Arts degree at the Courtauld Institute and then to carry out original research on the effect of the Italian Renaissance on 16th and 17th century English art forms.

He had a minor obsession that the British should or would turn metric in their drinking habits, and had, in preparation, already given Guy's a half-litre silver tankard. The set of silver tankards presented to him when he retired gave him much pleasure: he particularly wished these to be left to the Hospital in his memory.

C.W.M.A.

1. The Nurse and the Community

Miss B. Brysson Whyte

Introduction

Whenever a change takes place in the Health Service there must be some effect on those working in it. As nurses form a large proportion of Health Service staff, any proposed change in their function must be studied so that their training may eventually be adapted to fit them for their new rôle. As one report succeeds another it is difficult to know what is going to happen, but it seems certain that during the next few years the concept of integration between hospital and community will be firmly established and the patient will have continuous service provided by a group of people who know both him and each other.

Background

Before deciding on the best use of a nurse in an integrated service, it is necessary to examine her present rôle and try to establish what is considered as nursing at the present time. A study of nursing duties in this and other countries shows that nursing is an entirely cultural phenomenon. Tasks performed by a nurse in one country are performed by a doctor in another. Some societies make use of large numbers of ancillary workers, others use the patient's family. The line dividing nursing from other disciplines is as faint as it is arbitrary and the nurse in Britain may find herself deputising for either the doctor or the dishwasher, if they are not available. It sometimes seems as if nursing consists of all those tasks which no one else is either willing or able to perform.

The use of nurses on a wider scale has evolved in much the same haphazard fashion. Historically, hospital nurses, because the need of them was obvious, were trained in large numbers before the idea of a health visitor became universally accepted. Thus, with the exception of midwives, nurses wishing to work in the public health field must have a full hospital training before they start to specialise. This has two effects, firstly, it means that those who never move out of the hospital service have very little affinity with or understanding of their colleagues in the field, and secondly, that as the time available for training young women before they have their first babies is short, many who would have liked to train in public health work are unable to do so.

Present Situation

Tutors, and those responsible for the training of nurses, have for many years been trying to give students the idea that the patient is a

person whose hospital stay is only an episode in his life. The present syllabus, however, gives only a very limited picture, both of the patient and his background. Nurses can still complete a three-year training without nursing a psychiatric patient, except in a general ward. Similarly, their knowledge of his background is limited to the briefest visits of observation.

Even these brief visits pose enormous problems of organisation, and although numbers of nurses must have planned a career in health visiting following their glimpse of the work outside the hospital, those who spend their time organising the programmes very often wonder whether it is worth it. To give each student in a school such as this a single week in the field means that the public health department has to arrange some 1,500 visits annually. If the students are sent out too early in training they have not always developed that depth of understanding and tolerance which is necessary if they are to grasp what public health nurses are trying to do. If too late, they do not bring the benefit of this added experience back to their patients until they are very senior nurses and their attitudes have hardened. There is also a point at which observation of what others are doing has only a limited effect, and only by doing can real understanding be gained.

Introduction of the 1969 Syllabus

In 1969, the General Nursing Council, with the best of intentions and the minimum of consultation, produced a new syllabus. The resulting controversy has tended to obscure the fact that it is a very sensible syllabus. It lessens the emphasis on the range of clinical specialities in the acute hospital and introduces the broader concepts of psychiatric and geriatric care, making experience in one or other field compulsory by 1970. It also makes it compulsory for all nurses to gain experience in either obstetrics or community care by the same date.

The anticipated difficulty of implementing these proposals, especially in hospitals with large numbers of learners, highlights once again the consequence of using learners as the labour force in hospitals. It is much easier to believe that basic training refers only to the nursing of those patients who happen to be being nursed in one's own hospital, than to face the consequences of withdrawing learners to work elsewhere. Every student who is to gain experience in the community or in a special unit must come from the bedside of a patient in the parent hospital, leaving the nurse administrator with a depleted staff. There are many possible solutions to the difficulty, such as withdrawing certain areas of the hospital from training, making more efficient use of existing nursing staff, eliminating non-nursing duties, and reducing the number of students in training, but all these take money or more trained staff or both.

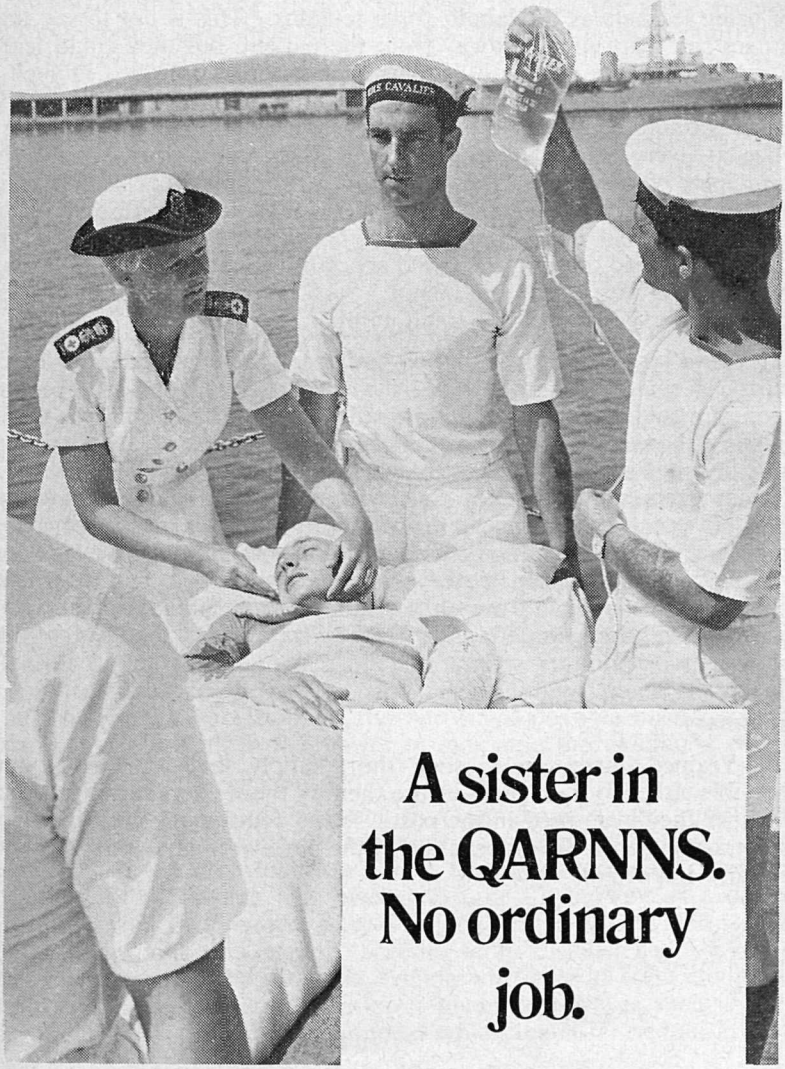
There is also the problem of who should supervise the learner during her community experience. Trained staff are already overburdened with numbers of other students and observers from other fields of work and can ill afford the time. In addition, the trained

There's nothing routine about life in the Queen Alexandra's Royal Naval Nursing Service.

If you're an S.R.N. you can become a sister. Within a year you could be working in Malta, Gibraltar or Mauritius. It's varied work looking after naval officers and men, their families, and local civilians. You enjoy the status of an officer without any military discipline. And you meet surgical and medical emergencies of every kind.

You get free accommodation, 44 days' paid leave a year, and a basic salary of £913 a year (extra for Registered Nurse Tutors), rising to over £2,000 if you're accepted for a full career commission. Gratuities are £765 for 4 years' service, £1147.10.0 for 6 years, and £1530 for 8 years.

If you've been an S.R.N. for at least a year, and you're under 37, write for further details (saying when you qualified) to Matron-in-Chief, Q.A.R.N.N.S., (26 LO) Empress State Building, London, S.W.6.



A sister in the QARNNS. No ordinary job.

public health nurse who, unlike the ward sister, is not used to having learners under her feet all day, is worried about how she can continue to give her patients the privacy and personal attention she believes they should have. She is anxious about the immaturity of the young student and the effect this may have on the good relationships with patients she has fostered so carefully over the years. Those in the hospital field, whilst understanding these fears, point out that in hospital young nurses have to work in far more stressful situations.

The Future

Surely the answer is that the 1969 syllabus is only a stop-gap and nurse training in this country cannot develop while the basic problem of using learners as the labour force remains. This is not to say that nurses can learn nursing away from the patient, but they could learn a great deal more efficiently if their training was controlled in such a way that theory and practice were integrated. If this was so, a really basic training could be planned which integrated community experience at every step. In two years the nurse could learn about the principles of care of the very old, the very young, the physically ill and the mentally ill. At each stage she would work or observe in the appropriate field both in and out of hospital. When she had completed her basic training she could specialise in the field of her choice whether this was in hospital or not. Such a training has been started here as an experiment for a small number.

On a large scale this solution could only be achieved after much effort. Replacement staff would have to be found and trained and money would have to be made available. In future, the school of nursing should ideally be hospital based but independently financed, and hospital and public health teachers should work side by side. It may seem at the present time that we cannot afford to attempt this, but can we afford not to do it? Trained nurses are in very short supply and are not always used in the most rational way at the moment. The first step to the efficient functioning of an integrated health service is to produce an "integrated nurse" ready after a two-year basic training to adapt to further training in the field of her choice.

Summary

Trained nurses are in such short supply that it is no longer possible either to train them or use them in the wasteful and irrational manner they were used in the past. If the concept of integrated care is important, then the preparation of the nurse who is to carry it out is equally important.

2. The Responsibilities of the Ward Sister in Training the Nurses

Miss P. M. Jefferies

During the course of her three-year training the nurse receives tuition from a large number of people. These are representative of varying disciplines and range from the tutors whom they meet initially to the Consultant Medical Staff in different specialities. However, the largest group of people she will encounter is that of the ward sisters, therefore one would imagine that these are the people from whom she should gain most of her skills. In view of this fact, it is only natural to assume that a great deal of responsibility is automatically accepted by the individual sisters at the time of their promotion, and from thence we are led to ask two questions. Firstly, how frequently, and to what depth do we analyse the meaning of this, and secondly, does every newly-promoted person fully realise the extent of her commitments?

Let us attempt to examine the rôle of the ward sister in relation to the Student Nurses.

No one would deny that the purpose of a hospital is to care for sick people; and within this framework those who are to continue with this, have to obtain their experience, and ability, since there is no other institution which can provide, to order, those requiring medical and nursing care. Those people therefore who are appointed to administer the wards are thus serving a dual purpose. They are responsible for the safety and well-being of approximately thirty people, while at the same time they allow apprentices with varying degrees of knowledge to perform the necessary ministrations. From this then, emerges the sister's first responsibility; namely, that she must be prepared to shoulder the burden of possible mistakes being made, and to do all in her power to eliminate the likelihood of this occurrence.

On another vein, the learning situation should be examined. We are told by the educationists that students assimilate knowledge most efficiently in an atmosphere which is free from excessive stress and tension. Now, anyone who elected to take up nursing as a career, thinking that they would have an ideal climate in which to be educated, would very rapidly become sadly disillusioned. Even to try and envisage a hospital functioning with eternal calm eludes the widest reaches of the imagination. There is however such a thing as organisation, and this is the ideal which the sister should attempt

to achieve. If she manages to do this efficiently, then, even when the pressures of work are very great, it should still not be impossible for the student nurse to learn. To a large degree during her training she observes, and then, having done so, imitates. If, therefore, what she sees is good practice, she will unconsciously absorb the facts and perform in a similar way at a future date. Conversely, if what she sees is bad practice, then the reverse will be true. In addition to this, if the ward sister creates an atmosphere in which the patients are happy, then usually the nurses will, on joining the ward staff, very quickly sense this and follow her example.

As a paradox to the last comment, however, it must be realised by the ward sister that in order to administrate efficiently and well there must be discipline. Student nurses are like children in this respect, and must have very clearly indicated to them the boundaries over which they should not trespass. They will, of course, in a fashion similar to children, try to exceed these. The ward sister must, however, accept that. Should she not exert the regulation firmly, the safety of the patients will suffer, both immediately and in the future. The nurse who is not taught discipline will not be capable of exerting it herself.

Then let us contemplate the behaviour of the ward sister. She has always to remember that she is under constant surveillance. Failure on her part to act professionally at any time will ultimately be noted. The way she conducts herself will be taken by her students as a code to be followed. If then she wishes to think that she is teaching well, she must constantly set an example which is worthy of being followed.

Finally, the sister should be prepared to act as an adviser to the students. Many of them are experiencing great problems of one kind or another, and she must be ready to discuss these. Ideally she should attempt to assess each nurse quickly, and in so doing will soon learn to select the ones who are not performing as they should. She might then be able to provide considerable help, and also assist in improving the nurses' standard of work.

These then are the responsibilities which the ward sister has to consider when first undertaking her duties. If she is conscientious in this, she will have the dual satisfaction, not only of having done her job well, but also of experiencing pleasure at seeing the nurses becoming proficient as a result of her tuition. If we wish to maintain a high standard of nursing in our hospitals, then, it is surely the work of those who have the greatest contact with the students, to endeavour to ensure it.

A HOSPITAL CHAPLAIN

by

The Reverend Ronald Kempster

In years gone by a ferryman used to ferry travellers across the Thames not far from where now stands the hospital. His job is but a distant memory, yet it can well serve as a picture of a hospital chaplain's work. For in many ways the chaplain is a kind of ferryman. He must be ready to move people from one shore to another when they wish to be moved: he must be ready to carry them from where they are to what can be a new position, a deeper understanding, a wider vision. Often he must wait until they wish to move, and certainly he can be of little help to the travellers unless he himself has done such journeys many times; unless he himself has experienced a deeper and richer life; unless he himself knows not only the suffering but also the joy; unless he himself has a clear grasp of what may be called "the dimension of wholeness".

It is now fashionable to distribute "job descriptions", and, of course, various jobs done by a hospital chaplain can be listed—visiting round the wards, conducting services in the chapel, leading discussion and Bible study groups, individual counselling, visiting the dying, comforting the bereaved, and so on. But, underlying all that is done must be the ability to establish personal relationships, to meet the needs of people wherever they arise, and to communicate not only oneself but the things of God. In this profession, as in many others, "being" is very often more important than "doing".

Even a brief acquaintance with the realities of life in the 1970's will be enough to show one that the place of organised religion in most people's lives is very slender. No longer can it be assumed that most people want the formal ministrations of the Church. Very few patients ask for Holy Communion when they are ill, and fewer still make their confessions or ask for the laying-on-of-hands. The indications are that in many parts of the country fewer than 25 per cent of the babies born are now baptised. One wonders how many of those who work in the hospital are committed Christians. And one has only to see how few people attend church regularly to realise the kind of milieu in which a chaplain of today must work. No longer can he take refuge behind the formal institutions of organised religion.

This is not to say that people no longer believe in God. Indeed, one is constantly humbled and challenged by those who do the work of God or suffer with the patience of Christ, who would never call themselves Christians or acknowledge that they know God. If a chaplain is aware of this, he will come to see that God is in every

human meeting and outreaching of love, and that in spite of many signs to the contrary, this is still God's world. Recent years have seen a revival of interest in the ways in which religion and medicine may co-operate, and many engaged in medicine now respect the fact of the psychosomatic unity of the person. As a consequence, the clinician, whatever his personal position in matters of faith, now recognises that ideally no case history is complete which does not record some understanding of the patient's thoughts and feelings about his place and purpose in the universe. Such understanding is not necessarily communicated in religious language, but if a chaplain is prepared to listen, he will learn much about people and their place in the world.

It is also interesting to note the increasing place of ethics in medicine. Obvious moral problems are raised by such issues as euthanasia, sterilisation, transplant surgery, and so on. Such matters require more than purely scientific expertise. It does not automatically follow that religion has a part to play here, but if a chaplain is aware of the issues involved, he may perhaps help those concerned with such problems when they come to make their decisions. Indeed, the place of religion as a basis for medical ethics is something that needs careful consideration in an age in which religion is unreal for many people.

A chaplain—and indeed any priest or Christian visitor—must be open to others with all the risk and opportunity that this entails. He must be sensitive to another's need, and be ready to identify himself with others—to weep with them that weep, and to rejoice with them that rejoice. He will spend much of his time listening and learning. Just because he is a Christian he does not have all the answers. Indeed, very often he finds himself sharing the doubts and the darkness of the suffering or dying patient, and he is constantly aware of his own inadequacy. And yet, if he is a person who can give and receive affection, and if he himself has a firmly rooted faith and trust in God, then others will feel this and be helped.

This, then, is a brief assessment of a chaplain's ministry and his place in the healing community. He comes with no drugs or doses but with remedies equally effective. He does not compete with but complements the world of medicine, linking human needs to divine resources. Often he will have to watch while others work, and pray while others speak, but in his ministry among patients and staff alike, he will seek to make God real and present wherever he may go. A hospital chaplain certainly does not have any monopoly of the truth, but if he can attempt to point through and beyond the natural world to the supernatural, and reveal something of God's power and love, then he can perhaps help to lead others to a deeper understanding of wholeness and a wider vision of God.

CORRESPONDENCE

Lawn Tennis Club

SIR,—Following criticism in the *Gazette* at the end of last season and the holding of the Annual General Meeting (on the 29th October), the tennis club decided on some measures which it hopes will create a greater interest in the club. Towards the end of March, questionnaires will be available in the East Wing, which it is hoped that any person who is keen to play tennis seriously and/or socially will fill in. This will mean that the secretary will have a list of names from which he will be able to inform those interested, in the activities of the club.

For the players keen to play competition tennis there will be at least two practice evenings at the start of term. The teams for the first matches will be chosen from the players at these.

We are also hoping to have mixed tennis one evening a week with a less serious emphasis. These will be held at Honor Oak Park, and start when the evenings are long enough.

We do hope that those players who have become disillusioned with the tennis club in the past will not shy away this year and help to get the club back to its former thriving self.

Yours faithfully,
ARNE COLMAN.

The Captain of Tennis,
Guy's Hospital Lawn Tennis Club.

NOTICE

GUY'S HOSPITAL STUDENT'S CLUB

The undermentioned have been elected representatives of their Groups to serve on the Student Club Council for the year 1971-72.

1st Year Medical Students.
R. S. Weedon.

1st Year Dental Students.
C. P. Stuart-Bennett.

2nd Year Medical Students.
T. J. Goulder, K. Freeman.

3rd Year Medical Students.
(1) To be elected, (2) To be elected.

2nd Year Dental Students.
T. B. Barnes, D. R. Jackson.

1st Year Clinical Medical Students.
T. J. Cox, D. J. Jones.

2nd and Subsequent Year Clinical Medical Students.
R. Ashman, Miss L. K. Hampson, T. Kidger, R. W. M. Wright.

1st Year Clinical Dental Students.
Miss M. P. Hooley, Miss J. A. P. Leithead.

2nd and Subsequent Year Clinical Dental Students.
D. J. Arnold, J. N. E. Buckley, D. R. Cottam, J. P. C. McGlone.

Hostels Representative.
A. R. Rogers.

SPORT

RUGBY

HOSPITALS CUP FINAL

Guy's v. St. Mary's

Result: won 14—3

After five years of famine Guy's, at last, reaped their just rewards by defeating a Mary's side to win the 1971 Hospitals' Cup final.

Guy's, fielding a side strengthened by the presence of Thorburn (London Scottish), Ross (London Irish), Neville (Blackheath) and Novak (Harlequins), clearly possessed the better pack and the more creative three-quarter line. Considering the small physical stature of the Mary's pack it was perhaps surprising that the Guy's forwards were unable to give their three-quarters more good ball than they did.

Guy's opened the scoring early through an opportunist try by Gibson from the line-out, after Novak had been bundled into touch close to the Mary's line. For the rest of the first half Guy's play seemed to lack purpose and indeed Mary's, on several occasions, came near to scoring.

Only minutes after the interval Mary's came right back into the game with a try by their winger after a blind side movement. Mary's success, however, was only transient, for as the second half progressed, Guy's forwards began to show their superiority. Neville and Thorburn were continually at the fore in this period, the latter making a number of outstanding runs deep into Mary's territory.

Perhaps the decisive score came after Ross made an outside break and put Campbell over for a try. Guy's with this three point lead managed to get the ball moving along the line but due to the fine tackling of the Mary's three-quarters, so typical of hospitals' cup rugby, Guy's were unable to score from this style of play. Jones at stand-off played a well balanced game, kicking, passing out and making the occasional break. He could well be a great asset to Guy's for many years to come.

Guy's last try came through Matthews whisking the ball from the hands of his opposite number after a scrum under the Mary's posts. Danford converted, and also kicked a penalty goal after Novak was brought down with a late tackle in the closing minutes.

Team: M. Danford, J. M. J. Novak, J. Ross, A. Campbell, R. Barrough, D. Jones, P. Matthews, D. Stuart, T. Gibson, G. Evans, C. Neville, R. Burt, I. Baker, C. Thorburn, A. Fallowfield (Capt.)

P.B.

SOCCER

A PLEA FROM THE SOCCER CLUB

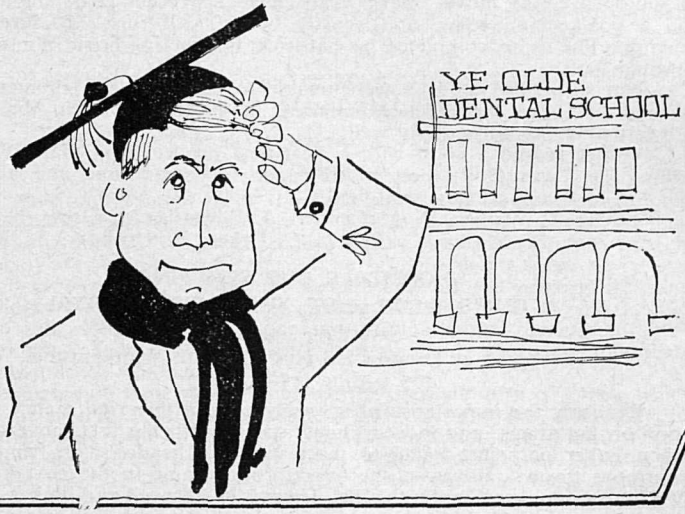
With one Hospitals' Cup in the bag, Guy's are again represented this coming Saturday, 13th March, in another final, the Inter-Hospitals' Association Football Final. Judging by the superb turn-out for the rugby, I would like to take the opportunity to say a few words on behalf of soccer at Guy's.

In seasons past the Soccer Club have had a somewhat subsidiary role to play in Saturday afternoon activities, and have been regarded as the "poor relations" of the Rugby Club. At the beginning of this season, the number of freshers seen at the trial, almost totalled the same number as seen at the rugby trial, and far outnumbered those at the hockey trial. In consequence, the Soccer Club has had a highly successful season, winning every round of the cup convincingly so far, a resounding victory being gained over St. Thomas's in the semi-final by 5—0.

I am sure everyone would agree that it would be a marvellous achievement to win all three cups this season, and in this light we would be extremely appreciative of as much support as possible on Saturday. Unfortunately, we do not have special coaches arranged. but trains run directly to the sports field (Cobham) every half-hour from Waterloo. I think you are assured of an interesting and entertaining game, the facilities being excellent with a large stand adjoining the pitch.

STEW DRAGE.

AFTER GRADUATION... WHAT?



The newly qualified Dental Surgeon leaves hospital with a fund of professional knowledge but generally ill prepared for putting this to the practice of earning a living.

The first assistantship is of paramount importance, with special emphasis on working with a Principal who can provide the right professional guidance and bearing in mind such essential matters as surgery conditions, remuneration, location and partnership possibilities.

LOCUMS LTD. specialize in launching young graduates into professional practice. Assistance to thousands of Dental Surgeons has been our business for many years. So consult Our Registrar today for free, friendly and helpful guidance. Ring—Write or Call:

LOCUMS LTD.

30 THURLOE STREET, SOUTH KENSINGTON, LONDON, S.W.7. Tel. 589 7292 (5 lines)

HOSPITALS LEAGUE
GUY'S 1st XI v. MIDDLESEX

At Chislehurst, 17th February. Won 6—1.

Guy's, showing the benefits of their hard training, began at a cracking pace and were rewarded with an early goal, scored from a corner by McClure. At this stage, Guy's were simply too fast for the usually competent Middlesex defence, and when Drage centred from the left, McClure was on hand to score. Guy's further increased their lead when Holliday scored following a superb five-man move. Baker then ended his recent goal famine by seizing on a goalkeeping error, and shortly before half-time, McClure, who was having a fine game, completed his hat-trick, hammering home Winter's accurate through ball.

Not surprisingly, Guy's were unable to maintain their momentum in the second half, but the defence remained in good form with McConnell and Edwards playing particularly well.

Winter scored a sixth with a near-post header from Harradine's perfect chip. This was Guy's best performance for some time and augured well for the forthcoming Cup semi-final.

Team: T. Walker, D. McConnell, J. Edwards, M. Drew, N. Harradine, R. McClure, M. Winter, G. Barker, C. Baker, H. Holliday, S. Drage.

HOSPITALS CUP SEMI-FINAL
GUY'S 1st XI v. ST. THOMAS'S HOSPITAL

Saturday, 20th February.

Played at London Hospital Ground, Walthamstow.

Result: Draw 2—2.

Realising the importance of an early goal in this vital match, Guy's were soon on the attack, and indeed almost scored with the first move of the game when Baker only just failed to reach Winter's headed flick from Holliday's enormous throw. However, the breakthrough came in the next minute when McClure's long pass split the St. Thomas's defence, and Baker steered the ball home. With the defence holding firm, and the forwards moving into space intelligently, Guy's began to dominate, and Holliday was unlucky not to score with a powerful volley that brought a brilliant reflex save from the St. Thomas's goalkeeper. With the first half drawing to a close, the match really came to life when Walker was beaten by a low shot, but luckily somehow managed to rush back and clear off the line. Coley, for ever at the centre of the action, was then involved in a heavy tackle and unfortunately had to leave the field with a badly gashed shin, Mike Drew substituting. When play resumed, McClure once again put Baker through, only for the centre-forward to screw his shot wide of the post.

Although the defence was often troubled by the speedy St. Thomas's wingers, Guy's kept pushing forward in the second half, and Baker missed a clear chance when Winter headed on Godman's free kick. Guy's, though, seemed to have clinched a place in the final when Drage beat his full back and chipped across for Holliday to score with a glorious header. However, shortly after the re-start, the defence stood still and appealed for a seemingly blatant foul on Drage, and when the referee waved play on, the St. Thomas's left-winger scored with a low shot that slipped through the tips of Walker's fingers. Clearly upset by this incident, Guy's now came under heavy pressure, but seemed to have survived, when Drew failed to clear an awkward bouncing ball in the closing minutes, and the St. Thomas's centre-forward nipped in to equalise.

Team: T. Walker, D. McConnell, A. Godman, J. Edwards, P. Coley, N. Harradine, I. McClure, H. Holliday, C. Baker, M. Winter, S. Drage. Substitute: M. Drew.

GUY'S 1st XI v. ROYAL DENTAL HOSPITAL
HOSPITALS LEAGUE

Played at H.O.P. on Wednesday, 24th February.

Result: Won 4—0.

Guy's were a long time getting into their stride, and though Drage had a goal disallowed for offside, and though Winter volleyed narrowly wide, it

wasn't until ten minutes before the interval that Baker fastened on to Winter's pass to open the scoring. A few well-chosen words from John Edwards at half-time galvanised Guy's into some semblance of form, and Winter headed home McConnell's cross to increase the lead. The best goal of the game soon followed, Baker scoring from close range after excellent work by Drage. Godman completed the scoring from the penalty spot after the opposition centre-half had unnecessarily handled McConnell's hopeful cross. Apart from Edwards and Harradine, this was an indifferent performance against one of the weaker sides in the league.

Team: T. Walker, R. Walsh, N. Harradine, M. Drew, D. McConnell, J. Edwards, A. Godman, G. Barker, C. Baker, M. Winter, S. Drage.

GUY'S 1st XI v. ST. THOMAS'S HOSPITAL
HOSPITALS CUP SEMI-FINAL REPLAY

Played at Cobham on Saturday, 27th February.

Result: Won 5—0.

Guy's made one change from the first game, Lindridge coming in for the injured Coley, with Harradine moving to centre-half and Winter switching back into midfield. The match could hardly have had a more exciting start with Guy's scoring in the first minute. There didn't seem to be any danger when Godman found Holliday on the edge of the penalty area, but the right winger cleverly laid the ball off for McClure to score with a well-placed shot from twenty yards. The pattern for the rest of the half followed that of the first match, Guy's dominating in midfield, but being unable to penetrate the solid St. Thomas's defence.

Few people could then have anticipated the dramatic turn of events which came after the interval. McClure, Godman and Winter began to expose previously non-existent gaps in the St. Thomas's defence, and within twenty minutes Guy's had added three more goals with a fine display of attacking football. The first of these goals was the result of good work by Baker, who turned sharply to hammer Drage's pass across the crossbar, and Holliday was on hand to nod in the rebound. Guy's went further ahead a few minutes later when McClure scored with a great shot which grazed the underside of the bar. There was no holding Guy's in this mood, and Holliday was again in the right place at the right time when the St. Thomas's goalkeeper failed to hold Lindridge's shot. Guy's added further insult to a demoralised St. Thomas's side by scoring a fifth goal in the closing stages, Baker calmly driving home Drage's cross.

This was a magnificent Guy's performance to win such an important game so handsomely, and was full reward for the hours of training put in by the team in preparation for this match.

Team: T. Walker, D. McConnell, N. Harradine, J. Edwards, A. Godman, I. McClure, M. Winter, H. Holliday, D. Lindridge, C. Baker, S. Drage. Substitute: M. Drew.

WATER POLO

UNIVERSITY OF LONDON UNION WATER POLO LEAGUE, 1971

GUY'S I v. LONDON I

Result: Lost 4—2.

Of perhaps all our matches this season, this was the one that we had a very real chance of winning. London's results had tended to be generally worse than ours throughout the season as both are going through the transition period when a team consists of an amalgamation of players of a past successful team and upcoming new players. It was still more interesting, in that we had been unable to keep an earlier fixture in the season, when we were due to play the London.

This was one of those rare occasions when Guy's had a full complement of nine players, which allowed substitutions. We suffered a strong blow with the

absence of Challacombe through injury. A strong two-yard forward, the team has learnt to rely on his consistency and correspondingly missed him immensely. Despite this setback, Guy's played well. Captain Chris Bevis had permutated for possible substitutions at the end of each quarter and only came unstuck by failing to use waterproof ink. John Clark played two-yard forward, his success in scoring was limited by both an enthusiastic London back and a talented goalkeeper, however his attempts were commendable and at times he resembled a semophore signaller suffering from an itchy back. Bevis, playing back, overlapped during the game to score a goal that looked as easy as being ordered out. The latter fate fell to the "evershuttling" Rod Bowering, who realising that we were starting the third quarter a man down through oversight, eagerly jumped from the side of the pool as the referee blew his whistle for the start. He gained the rare distinction of being ordered from the pool before the game had restarted. Graham Northcott played his usual game. Perhaps holding on to the ball when he could have passed to an overlapping player, he then proceeded to redeem himself by making some brilliant shots at the goal and was very unlucky in failing to score more.

The substitutes worked well and included three different goalkeepers, the final score was not a reflection of their lack of ability, but more an overall failure by the Guy's team to quickly mark our opponents as they broke through in attack. Due to this we deservedly lost four goals to two.

Team: C. Bevis (capt.), G. Northcott, J. Clark, T. Sands, A. Winder, F. Cordingly, R. Bowering, A. Hellyar, G. Newman.

T. S. & S.

HOCKEY

HOSPITALS CUP SEMI-FINAL

Result: Guy's 1, King's 0.

The 1st XI met King's for the third time this season at Cobham, where the conditions were perfect. There were even two umpires.

After the previous week's farce which ended in a 0—0 draw, Guy's certainly set their minds on winning, for the first fifteen minutes anyway, after which a superior Guy's side were quite content to allow King's over 50 per cent of the ball. Thanks to B. Fell and M. Vellacot, their attack rarely came to much.

The Guy's build-up was generally good. However, the skill of the lost pass seems to elude Guy's. A miss hit short corner put R. Burns in a scoring position; he gave the King's defence no chance. One up, the pressure was released and Guy's began to settle down. Altogether, the ball was in the King's net five times, which emphasises the fact that the umpiring was five times better than the previous week.

The side are now set to play a strong St. Thomas's XI, for which support would be greatly welcomed. It seems ironical that for the last two games, the only support has been from a Thomas's man.

Team: B. Clark, N. Matthews, M. Vellacot, P. Nicol, B. Fell, P. Calvert, P. Willmer, R. Burns, B. Clark, P. Duckworth, J. Shutes.

P.A.J.W.

Result: Guy's 0, Gore Court 1.

After a dismal performance in mid-week against King's Hospital (result 0—0), a weakened Guy's team went down to Sittingbourne to play a Gore Court side that had lost only two previous games, and that boasted three Kent players.

As is usual in the hockey club, one of the best performances of the season was reserved for this strong fixture. The defence as a whole played outstandingly, and Guy's were perhaps unlucky to be one goal down at half-time.

In the second half the forwards began to assert themselves and settled down to play some fine hockey. Once again, however, lack of finishing power made a mockery of the result. The Gore Court defence was fully extended nevertheless, and Guy's were unlucky not to score from two sweetly struck short corners, taken by D. Crafts.

With Guy's more and more in the ascendancy as the match progressed, Gore Court showed obvious signs of relief on hearing the final whistle.

Team: R. Clark (snr.), N. Matthews, D. Crafts, P. Nichol, R. Fell, P. Calvert, J. Walker, P. Duckworth, R. Clark (jnr.), R. Burns (captain), J. Shutes.

N.P.C.M.

BOAT CLUB

MAY AND BAKER CHALLENGE TROPHY

10th February, 1971.

1st VIII's

Guy's beat Bart's—3½ lengths.

Bart's had persuaded all their purple, ex-purple and international oarsmen to make the trip to Chiswick in order to win this trophy. Guy's boated 6 of their 1st VIII squad and were joined by Tony Fenn (University 1st Boat) at 4, Paul Stuart-Bennett (Kingston 1st Boat) at 5, and Fred Moorhouse (University 2nd Boat) as cox.

The fitness of our VIII proved too much for Bart's, who hung on ½ length down for the first half mile but faded badly towards the finish giving Guy's an easy and impressive victory.

Crew: Bow, C. J. Price; 2, G. Moulding; 3, A. Batch; 4, A. Fenn; 5, P. Stuart-Bennett; 6, P. Stevenson-Moore; 7, R. Pinckney; Stroke, M. J. Gleeson; Cox, F. Moorhouse.

WORLD MEDICINE TROPHY

2nd VIII's

Bart's beat Guy's 1½ lengths.

This was a disappointing result for Guy's who the previous week had finished only 4 feet down on the same crew at Putney. The reason for the failure probably lay in the fact that the crew order and constitution had been changed slightly in the hope of making it faster by the inclusion of some of the 1st and 3rd VIII squad. Obviously this didn't work and as a result we paid very heavily for our experience.

Crew: Bow, P. Read; 2, T. Fox; 3, H. Fuller; 4, R. Newman; 5, G. Robbins; 6, D. Barker 7, S. Large; Stroke, D. Curtin; Cox, D. Evans.

UNIVERSITY OF LONDON HEAD OF THE RIVER

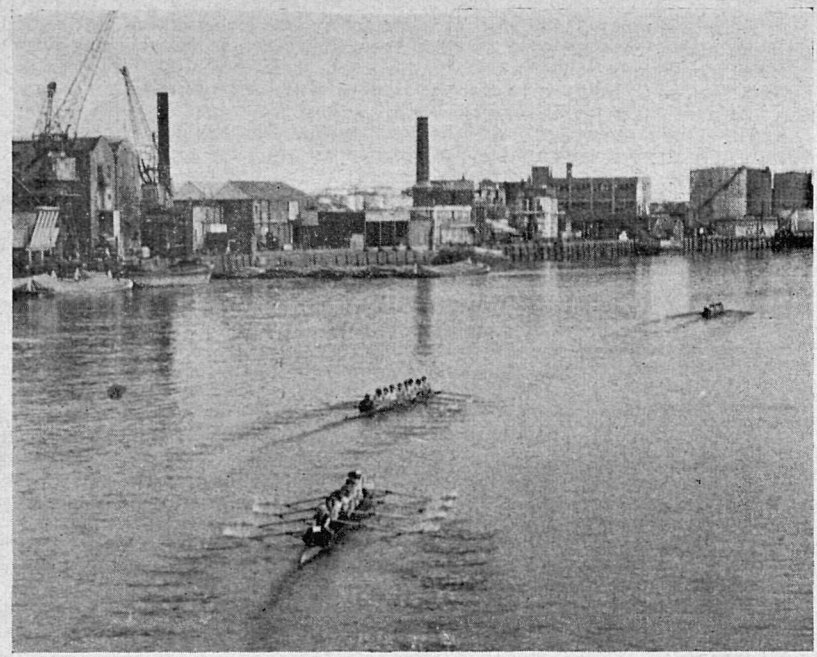
24th February, 1971

Result: Guy's 1st VIII—Winner Dixon Bowl, Senior VIII's 19 mins. 34 secs. 2nd overall to the University Boat which was 26 seconds faster.

Guy's 2nd VIII—14th position overall. (19 crews entered).

The Head was rowed this year over the Tideway Course from Chiswick Road Bridge to Putney Bridge Pier. Most of the 1st crew had trained five days a week since January, the remainder since last September. Training consisted of Wednesdays, Saturdays and Sundays on the River and Tuesdays and Thursdays in the Gym. Guy's had never won this trophy before, it usually being held in Imperial College. Indeed the last time Guy's won a Senior VIII event in the university was 47 years ago when they won the Allom Cup 1924. (In fact they were first home again in 1925 but were disqualified for boring.)

The crews were set off at 10 second intervals, the 1st crew following Imperial College I and the University and chased by Imperial College II and St. Thomas's Hospital. The VIII did not settle down until past Barnes Bridge when they rowed through their wind and started to reduce the gap between themselves and Imperial College who had been overhauled quickly by the University. The race was rowed in accordance with a predetermined plan



which split the course into 4 separate stages, each of which had a certain work programme e.g. sprints between certain landmarks developing into strides, when the boat had gathered enough momentum. At Hammersmith the gap was 2 lengths and no crews appeared to be making water behind—in fact quite the opposite. At the beginning of the final piece the crew could hear the frantic shouts of the Imperial Cox and see their paddles bubbling by our stern. By Fulham Football Ground the crews were level, and aided by the exhortation from our cox and cheers from the starting marshall's launch the VIII powered through Imperial and ended 1½ lengths ahead at the pier—12 seconds ahead, in the final analysis, from the next crew. A truly magnificent row during which every man gave all he could. Credit must also be given to the members of the 1st VIII squad not rowing on this occasion but with whose help the crew attained this victory.

Crew: Bow, C. J. L. Price; 2, G. Moulding; 3, A. Batch; 4, A. Chivers; 5, P. Stuart-Bennett; 6, P. Stevenson-Moore 7, R. Pinckney; Stroke, M. J. Gleeson; Cox, D. Evans. Reserves: D. Barker, P. Newton, H. Fuller. Coaches; N. D. S. Bax, J. C. Miller.

2nd VIII

Despite an impromptu swim in the Thames by their cox prior to starting the VIII negotiated their first head with perhaps too much caution but indeed with a certain degree of success. They paid the penalty of slackness at the start, when they should have been hot on the heels of the crew in front, by rowing in a vacuum. No doubt they will make certain of a good start next time and will be able to judge the distance better as well.

Crew: Bow, M. Browne; 2, D. Carman; 3, J. Squires; 4, G. Robbins; 5, L. Rabb; 6, K. Freeman; 7, S. Large; Stroke, D. Curtin; Cox, G. Brown.

ANGELS' SOCIAL AND SPORTING CLUB, 1970/71

President: S. E. Barrow, Esq. Captain: C. Ryan, Esq.

Despite national and local comment on the decline of Hospitals' Rugby in recent years, the present crop of Angels are playing the sort of stuff which

Nursing in Depth

March 1971 sees the publication of the first four titles in this important new series of nursing handbooks. The authors are all well known in British nursing, and the intention is to provide in each volume a detailed survey of facts and practice in a specific aspect of the nurse's work. Pocket-size and at an incredibly low price, they will be ideal for the student nurse as study guides, revision aids or as the basis of refresher courses for women returning to the profession after a break.

Circulatory System

Physiology and Pharmacology

Florence Pallett, SRN, SCM, RNT.

CONTENTS: The Heart. Blood and Red Blood Cells. White Blood Cells. Blood Coagulation. Blood Vessels. Blood Pressure. Drug Administration.

0 407 81560 0. 96 pages. Illustrated. 1971. **45p**

Dressing Techniques

W. E. Broome, SRN, QN, RNT.

CONTENTS: Introduction. Equipment for the Dressing Technique. Sterile Procedures. Wound Healing. Psychological Approach. The Dressing Trolley. Wound Dressing. General Attention. Baths. Complications. Drainage and Wash-out. Rehabilitation. Dressing Technique in the Casualty Department.

0 407 81890 1. 96 pages. Illustrated. 1971. **45p**

Nursing the Incontinent

Eric Edmondson, SRN.

CONTENTS: Thinking about Incontinence. Urinary Incontenence. Helping the Patient to Cope. Mechanical and Medical Aids. Faecal Incontinence and Unusual Cases. The Daily Round. Home and Hospital. A Man's a Man.

0 407 87705 3. 92 pages. Illustrated. 1971. **45p**

Pressure Sores

Prevention and Treatment

Keith A. Walker, SRN, RMN, DN(Lond), DIFPC.

CONTENTS: Introduction. The Terms Defined. The Pathology of Pressure Sores. Prevention of Pressure Sores. Local Preventive Methods. Treatment of Pressure Sores.

407 87705 3. 92 pages. Illustrated. 1971. **45p**

Available from leading booksellers or

The Butterworth Group

88, KINGSWAY, LONDON, WC2B 6AB

Showrooms and Trade Counter, 4-5 Bell Yard, London, WC2.

would gladden the heart of many a Guy's veteran.

Although perhaps not approaching the game with the same dedication to training, which is proving so popular, though of debatable value, in modern Rugby, their attitude on the field, and results lack nothing for it.

The record for the season thus far stands at won 14, lost 5; and while some notable teams have been beaten, 4 of the defeats have been close affairs and the fifth a 22—0 loss to London Scottish III. Teams beaten include Rosslyn Park III (9—8), Charing Cross II (19—0), Old Whitgiftians (68—3), Met. Police (23—5) and O. Elysians (14—0), while one must not forget the 35—3 massacre of the Boat Club, who were fortunate to find the Angels having an off-day.

To do justice to individual players would be long and boring, although Rex Yetton perhaps deserves a mention for scoring over 100 points before Christmas, mainly by tries. Christmas also saw the passing of three long-standing Angels to better pastures—Marc Evans to Cardiff; Grubby Cope to Cornwall; and Frank Haines to Clapham. Haines' rendering of "My Baby Does The Hanky-Panky" is one of those never-to-be-forgotten experiences in one's life, while the contribution of the other two both on and off the field was of the highest standard.

The proposed Easter Rugby Tour to Ireland seems to have floundered because of the postal strike, which stopped any communication between Guy's and the Irish medical colleges. However, there is always next season.

On the social side, an Angels Dinner was held in the Lower Grapes on Wednesday, 17th February, which was attended by 18 members. This was a memorable evening in many respects, not the least of which was the meal we received. It also saw the awarding of Angels "Yellows" and "Half-Yellows" for outstanding service on the field of play. A special Jersey-badge has been designed, and the following awards were made:

Full Yellows: R. Yetton, K. Moseley, G. Dunbar, A. Valentine, L.R.C.P., M.R.C.S., D. Arnold.

Half-Yellows: C. Ryan, P. Watkin, R. Wilson, A. Royston, D. Glen.

The award entailed the recipient drinking a full or half-pint accordingly, and there is some controversy as to whether Mr. Moseley's actions meant he would have preferred a half-yellow.

Returning to the sporting side, the Angels have been putting out a successful Sunday Soccer side, whose record is played 5, won 4, drawn 1, for 23, against 11. Reports of these matches appear below. If anyone can raise a team of any description and would like a fixture on any Sunday (Soccer, or anything else) then please contact C. Ryan or R. Wilson (East Wing Bar).

The oarsmen in the society are flexing their muscles in preparation for the UL. Regattta, in which the Angels hope to enter two VIII's. Let it never be said that a challenge from the Boat Club went unanswered.

While summer may seem a long way off, the cricketing Angels can be seen of an evening strengthening their wrists and forearms, and sharpening their reflexes on 2 specially-designed machines located in the bar. A far better method of preparation than oiling one's bat!

In conclusion, the Angels would like to extend a warm welcome to their first-ever president, that well-known and loved Guy's figure, Ted. May he derive as much pleasure from the position as we do from having him in it.

A. GABRIEL

ANGELS' FOOTBALL

Since the Angels appeared to excel at all sports, it was decided this year to form a Sunday Football Club. Unfortunately, they found some difficulty in finding opponents. However, five games have been played so far this season, and as many predicted, the Angels have remained undefeated.

The first game of the season was against a Guy's 3rd XI, strengthened by a number of experienced players. The Angels took some time to settle and soon found themselves several goals down. However, they started to play with greater accuracy and gradually evolved an extremely effective style of play which was to be evident in all their future successes. The opposition was completely dazed and a veritable barrage of shots reduced the goalkeeper to a nervous heap. The Angels' forwards dealt similarly with the remaining defenders and were unlucky to score only seven goals.

Result: Angels 7 Guy's 3rd XI 4.

The next game was against Plumstead Pacific, a fast improving amateur side from South London. Against a side of such experience the Angels were a little tentative, but their forward thrusts soon proved that they were able to pierce the armour even of this team. The persistent flow of attack and counter-attack provided the crowd with moments of intense excitement. However, the Angels' defence kept a tight control, looking at no time in any real difficulty. With this impenetrable wall to their rear the linkmen of the side employed some fine tactical play, and with the finishing power of the forwards the Angels were three goals up by half-time. It is said by some that the true strength of a side lies in their ability to recover from certain defeat. Despite three quick goals early in the second half, Plumstead Pacific were absolutely unable to do this, and the Angels punished them with a further two fine goals.

Results: Angels 5, Plumstead 3.

* * *

Plumstead Pacific were much chagrined at this defeat and asked for an immediate replay. This was arranged, and so as not to demoralise this valiant side too much, a weaker Angels' XI was fielded. However, even then, the Angels were superior in all aspects of their play. Plumstead doggedly persisted, however, and with sheer brute force trampled into the turf the finesse of the Angels. With such different styles the final result of 4 goals all was inevitable.

Result: Angels 4, Plumstead 4.

* * *

The Angels, flushed with success, sought a more difficult fixture and this was provided by the Guy's 2nd XI. Whilst the Angels approached this game with determination, the 2nd XI viewed it with a casual over-confidence. The first half began slowly and the game was locked in a midfield duel, niether side showing any inspired, incisive forward play. For the 2nd XI Harradene played a fine game, repeatedly pushing through accurate passes for his forwards. However, hesitation on their part and fine goalkeeping by Robinson, prevented them scoring. Fifteen minutes into the second half the Angels took the lead after a bouncing off-spinner by Watkin completely deceived the 'keeper. In the next 20 minutes Perl and Royston were both unlucky not to score in what seemed on both occasions a deserted goal. The 2nd XI counter attacked with more skill than they had shown before, and only the sensible playing of Parker and Glen and the brilliance of Epsom contained their vivacity. In the dying minutes McConnel split the defence and a certain goal was prevented by Jones handling the ball on the line. After some deliberation, Epsom (who has never been known to miss a penalty) was summoned to the spot. Cunningly sending the 'keeper diving for the far left-hand corner, Epsom took a mighty lunge and trickled the ball just inside the right post.

Result: Angels 2, Guy's 2nd XI 0.

* * *

The last game of the present series was against Belgravia United, a well-known club trained by a Queen's Park Rangers' Scout. From the start it was evident that United were a tactically well drilled side and had a considerable depth of footballing talent. They dominated the midfield play and created chances with thoughtful deliberation. However, due to the stoicism of the Angels' defence and the lack of incisiveness of the United forwards, these chances were squandered with prodigal abandon. The Angels were tightly pressed and found little space to employ their skills to advantage. However, they always looked more dangerous in the box, and just before half-time Wilson took a well-deserved goal. Early in the second half it became obvious that United had released all their rockets earlier in the game and were clearly tired and disappointed at their ineffectuality. The Angels were given greater space to move in and their superior physical prowess began to pay dividends. Watkin headed the second goal from a corner and then further goals by Wilson, Valentine and Drew rubbed salt into the now festering wound.

Result: Angels 5, Belgravia United 0.

HOSPITAL INFORMATION

GUY'S HOSPITAL

Applications are invited for the post of **Registrar** in Psychological Medicine at St. Olave's Hospital of the Guy's Board of Governors with duties to commence as soon as possible until 30th September, 1971 in the first instance. Forms of application are obtainable from and should be returned to the Superintendent, Guy's Hospital, S.E.1, *or* telephone 01-407 7600 Extension 318, not later than **19th March, 1971.**

GUY'S HOSPITAL

Applications are invited for the appointment of **Locum Registrar** in Anaesthetics to the Guy's Group of Hospitals for the period 1st April to 30th September, 1971. Forms of application are obtainable from and should be returned to the Superintendent, Guy's Hospital, S.E.1, or telephone 01-407 7600 Extension 318, not later than **19th March, 1971.**

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited from registered dental practitioners for the appointment of **Lecturer** (full-time) in the Dental Department for Children with duties commencing 1st July, 1971. Salary within the range of £2,450 to £3,926 with superannuation. Forms of application are obtainable from, and should be lodged with, the Dean, Guy's Hospital Dental School, London, S.E.1, not later than **31st March, 1971.**

PAPERS BY GUY'S MEN

Batchelor, J. R., Ellis, F., French, M. E., Bewick, M., Cameron, J. S. and Ogg, C. S. Immunological enhancement of human kidney graft. *Lancet*, 1970, **2**, 1007.

Brock, Lord. The Department of Surgical Sciences. *Annals of the Royal College of Surgeons*, 1970, **47**, 344.

Calne, D. B. L-Dopa in the treatment of Parkinsonism. *Clinical Pharmacology and Therapeutics*, 1970, **11**, 789.

Calne, D. B. and another. Parkinsonism and cardiac arrhythmias. *Lancet*, 1970, **2**, 1313.

Calne, R. Y. and others. Fate of kidney allografts from cadavers whose livers were also transplanted. *Lancet*, 1971, **1**, 103.

Clark, T. J. H., Collins, J. V., Evans, T. R. and Tweedily, K. A review of experience operating a general medical intensive care unit. *British Medical Journal*, 1971, **1**, 158.

Collins, J. V., Harris, P. W. R., Clark, T. J. H. and Townsend, J. Intravenous corticosteroids in treatment of acute bronchial asthma. *Lancet*, 1970, **2**, 1047.

Cooke, S. A. R. The site of calcification in the human renal papilla. *British Journal of Surgery*, 1970, **57**, 890.

Cox, R. A. F. An emergency plan for an offshore disaster. *Practitioner*, 1970, **205**, 663.

Cremin, B. J. and another. The "eye squirt sign" as a radiological sign of ureterocele formation. *South African Medical Journal*, 1970, **44**, 1217.

Das, P. K. and Liddell, J. Value of butyrylthiocholine assay for identification of cholinesterase variants. *Journal of Medical Genetics*, 1970, **7**, 351.

Draper, R. and Rees, R. J. W. Electron-transparent zone of mycobacteria may be a defence mechanism. *Nature*, 1970, **228**, 860.

Fitzgerald, D. E., Gosling, R. G. and Woodcock, J. P. Grading dynamic capability of arterial collateral circulation. *Lancet*, 1971, **1**, 66

Hunt, J. N. and another. Controlling gastric acid. *British Medical Journal*, 1971, **1**, 173.

Jarrett, R. J. and Keen, H. Further observations on the diurnal variation in oral glucose tolerance. *British Medical Journal*, 1970, **4**, 334.

Jarret, R. J., Keen, H. and Hardwick, C. "Instant" blood sugar measurement using dextrostix and reflectance meter. *Diabetes*, 1970, **19**, 724.

Killey, H. C., Kay, L. W. and another. Subperiosteal osteomyelitis of the mandible. *Oral Surgery, Medicine and Pathology*, 1970, **29**, 576.

Lehner, T. Immunopathology of oral leukoplakia. *British Journal of Cancer*, 1970, **24**, 442.

Lehner, T. Serum fluorescent antibody and immunoglobulin estimations in candidosis. *Journal of Medical Microbiology*, 1970, **3**, 475.

McHardy-Young, S., Doniach, D. and Polani, P. E. Thyroid function in Turner's syndrome and allied conditions. *Lancet*, 1970, **2**, 1161.

Missen, G. A. K. and Roberts, C. I. Calcification and cusp-rupture in human aortic-valve homografts sterilised by ethylene oxide and freeze-dried. *Lancet*, 1970, **2**, 962.

Moynahan, E. J. Skin disease and the gut. *British Medical Journal*, 1970, **4**, 559.

Northfield, T. C. Factors predisposing to recurrent haemorrhage after acute gastro-intestinal bleeding. *British Medical Journal*, 1971, **1**, 26.

Ogg, C. S. and Cameron, J. S. Hepatitis in renal transplantation. *British Medical Journal*, 1970, **4**, 412.

Ogg, C. S. and Cameron, J. S. Hapatitis in dialysis units. *British Medical Journal*, 1970, **4**, 552.

Polani, P. E. and another. Y heterochromatin and XX males. *Nature*, 1970, **228**, 1215.

Polani, P. E. and Mutton, D. E. Y-fluorescence of interphase nuclei, especially circulating lymphocytes. *British Medical Journal*, 1971, **1**, 138.

Rhys Williams, D. R. and Coulson, A. S. Lymphocyte transformation in protein-free medium by concanavalin A. *Lancet*, 1971, **1**, 80.

Sims, W. The concept of immunity in dental caries. I—General considerations. *Oral Surgery, Medicine and Pathology*, 1970, **30**, 670.

Sullivan, F. M. Mechanisms of action of teratogenic drugs. *Proceedings of the Royal Society of Medicine*, 1970, **63**, 1252.

Trounce, J. R., *ed. A guide to drugs in current use*. Medical and Technical Publishing Co., 1970.

Watts, D. C. and others. Correlation function approach to the dielectric behaviour of amorphous polymers. *Transactions of the Faraday Society*, 1970, **66**, 2503.

Zorab, P. A. and others. Hydroxyproline excretion and height velocity in adolescent boys. *Archives of Disease in Childhood*, 1970, **45**, 763.

GUY'S HOSPITAL GAZETTE

EDITORS N. D. S. BAX and A. M. TURNER
NEWS EDITORS R. M. DARLING and J. L. LEWIS
SPORTS CORRESPONDENT A. M. ROYSTON
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TEN PENCE VOLUME 85 NUMBER 2157

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Medicine finds new specialities daily. In keeping with the current trend of hyper-specialization, three recent lectures for clinical students involved more than one participant, each covering a topic in which they specialize. Second M.B. students have had the advantages of this style of delivery for some time. The group participation lecture is on the whole both more interesting and beneficial for the students. Fashionable though it is to offer condemnatory feed-back, we congratulate the deliverers of these lectures.

The revival of the Clinico-Pathological conferences as lunch-time lectures is a good thing, as was evident by the Anatomy Theatre being full. Let us hope it is the first of many. There are, however, unfortunately, times when one goes to a lecture with high expectations only to sit through a slideless and colourless presentation. Alternatively, a lecture may be nothing other than a read slide show. Teaching is difficult and being a first-rate doctor does not necessarily qualify one as a good lecturer. It is very heartening to see some departments taking a keen interest in developing and improving teaching techniques. All will not maximally benefit from one method of teaching; indeed, it is virtually impossible to define what is meant by "maximally benefit", let alone measure it. One can only hope that these three lectures presented over the past few weeks and the students' enthusiastic response to them, is sufficient to induce other lecturers to follow suit. When the present 2nd M.B. students start on the wards they will be disappointed if there is a decline in the standards of teaching.

The Age of Maturity

Let us imagine bringing up our sons and daughters to discover the pleasures of bodily contact from their earliest months. At the

same time as teaching them to talk, dance, jump about, paint pictures, write, eat and play, all of them well-known devices in adult pleasure and love-making, we also familiarise them with cutaneous sensation, or making love as it is restrictively known. What would be the consequences?

Well, one of the first problems we should fear is that the youngsters would age too quickly. At the moment it is considered appropriate to leave alone or even actively hinder such activities until perhaps four years after puberty, when hormonal influences, long under social strictures, finally tolerate no more and overwhelm the personality in many people. The situation has well known associations of guilt, rebellion against elderly repression and secretiveness on the part of the adolescent about his desires. Yet it also delights parents, pleased to see their children simply enjoying a love for toffee apples and rugby, uncomplicated by the need to work out the as yet unrecognised problems of physical relationships that they will encounter soon enough. We should lose the poetry of discovering for the first time what it is like to touch and be touched by an attractive person, because that would be a sensation well known to us before we started to interpret experiences romantically, however that would destroy neither childlike pleasure at simple things nor the joys of early romance : children would be working with a wider vocabulary and might possibly appear to be deriving more benefit from it.

We are also scared for them that if they have complete freedom with many partners then they will be unable to form a stable, lasting relationship with anyone at all. That is undoubtedly true of some people, but we must also remember that people of wide general experience, even under present conditions, are able to respond in a special and faithful way to the partner they find they love, in language, manners and sexual behaviour.

There is lastly the problem of disease. The diseases transmitted through sexual contact are common and not wholly curable. They would become more common and more frequently intractable to treatment if we encouraged unrestricted bodily contact. It would be madness to teach youngsters to practise a pursuit freely when it often leads to a lifetime of misery and sterility. Here is the drawback and it is here it should be recognised.

GUY'S DIARY

MARCH

29	M	1.00	Clinical Lecture. Dr. JOSEPH. "Childhood Asthma."
30	Tu	1.00	Clinical Lecture. Dr. GRIMBLE. "Teenagers and Sexually Transmitted Infection."

APRIL

1	Th	1.00	Clinical Lecture. Mr. GLOVER.
2	F	1.00	Clinical Lecture. Dr. KAUNTZE. "Gout : A Reprise."
5	M	1.00	Clinical Lecture. Mr. HENRY. "Arthroscopy."

NEWS IN BRIEF

Residents' Bar

The Residents' Bar was closed for three days last week because it was found to owe the brewery which supplies it £1,700, the result of one or two unpaid bar bills. This drastic measure had the desired effect, for £1,000 or so was collected in three days, and to the unanimous relief of the Residents, the bar was re-opened. The Residents seem to have survived the harrowing experience with quite extraordinary resilience: we are reliably informed that the hallucinations, disorientation and restlessness experienced by some of their number was quite unrelated to the absence of alcohol.

Bacteriology, Obstetrics and Gynaecology Prize Exams.

Exams for the Golding-Bird Medals and Scholarships in bacteriology and obstetrics with gynaecology are to be held on 14th May and 5th May respectively. The prizes were founded by the late Mrs. Golding-Bird in memory of her husband, Dr. Golding-Bird, F.R.S., Assistant Physician to Guy's Hospital, 1843-1854.

Each consists of a gold medal, and a sum of money of about £14. Entries close on 28th April for the bacteriology prize, and 16th April for obstetrics and gynaecology.

"What Kind of Doctor?"

On Monday, 15th March, B.B.C.2's "Horizon" showed a documentary on undergraduate medical education, using St. Thomas's Hospital as their subject. Apparently the B.B.C. originally approached Guy's, who declined because of doubts about the degree of balance likely to be achieved. Those who saw the programme will be able to judge whether this attitude turned out to be justified or not.

The Friends of Guy's Hospital

During the past few months negotiations have been going ahead for the amalgamation of the Guy's Hospital Ladies' Association and the Guild of Ex-Patients and Friends of Guy's Hospital, to form a new Association to be known as The Friends of Guy's Hospital. The amalgamation is subject to the approval of the members of both organisations at their Annual General Meeting, at which the object of the amalgamation will be explained.

Research News : Malaria

Members of the department of Chemical Pathology, Dr. Butcher, Mr. Mitchell, Mr. Dennis and Professor Cohen, have been working on the development of a vaccine against malaria. This work until 1968 was outlined in the *Gazette* of 22nd June, 1968.

Contrary to the popular view in many Western countries, malaria is still a major health problem in Asia and Africa, with no prospect of eradication in the next 10-20 years. It is estimated that there are 50 million cases per year in the world, with one million deaths, and that 350 million people are exposed to the disease. It is easy to see that, while the implementation of eradication programmes remains impossible, an effective vaccine could be of great value.

In 1960, Professor Cohen, working with Dr. McGregor in Gambia, showed that severe attacks of malaria in young Gambian children are rapidly cured by the injection of gamma-globulin from adult Gambian subjects who had become immune through repeated injection. This implies that acquired immunity to malaria depends on circulating antibodies, found to be of the IgG class, which cross the placenta from mother to foetus and so confer immunity during the first few months of life.

Since 1968 a method for short-term culture of the malaria parasite has been developed, in which the parasites undergo one complete cycle of development, and multiply at a physiological rate. This has not been achieved before. By studying the uptake of tritiated leucine by the parasites, their rate of protein synthesis can be measured, and this provides an accurate and convenient index of growth. The introduction of immune serum into this system inhibits growth of the parasites when they burst out of the red cells into the plasma after cell division, and has no effect on parasite growth when they are inside the red cells. Phase-contrast microscopy reveals that immune serum produces agglutination of parasites and prevents their re-entry into the cells—re-entry of parasites in the absence of immune serum has been filmed using this technique. The protective antibody, which is not complement-dependent, is thought to act by coating the parasites while they are in the plasma, and preventing their attachment to red cells.

Work is continuing on the antigenic properties of the parasite, with the aim of isolating antigens which will stimulate the production of the protective antibody. Such antigen preparations should provide an effective antimalarial vaccine.

Professor S. de Navasquez

A memorial service for the late Professor S. de Navasquez will be held in the Guy's Hospital Chapel on Monday, 5th April, at 12.30 p.m.

Clinical Day 1971

Clinical Day 1971 was held on 6th March and, despite the postal strike, sub-zero temperatures and flurries of snow, the number of alumni attending was up to standard. As Old Guy's men converged on their Alma Mater their eyes were cast heavenwards as they beheld the Tower rapidly approaching its "topping out". Comments overheard in the front quadrangle ranged from "Good Gracious", "Heavens above" to "Let's hope the lifts don't break down". However, once in the warmth of the Dental School they quickly saw that things were very much the same; the clinical demonstrations were just as numerous and ingenious as ever, and everyone was in good heart.

The offering from the Department of Conservative Dentistry was orientated essentially around endodontics and among the subjects covered were use of rubber dam, endodontic instruments, root canal drugs and materials, and pulp capping. Working conditions in the dental surgery also received considerable attention and this important subject was much appreciated by a large number of the visitors, especially those in practice. There was high level dentistry, four- and six-handed dentistry, fibre optic lighting, but probably the most interesting of all was posture. This demonstration comprised a series of cartoons, photographs and radiographs illustrating most dramatically the various skeletal contortions in which the dentist might find himself whilst carrying out chairside work.

In the Children's Department both orthodontic and paedodontic problems were tackled but considerable interest was generated by the demonstration of the Thamesmead Project showing the dental services in the context of the health facilities at this new town and the various planned phases of its growth.

In the Prosthetics Department there was much to interest the practitioner which included a tape-slide demonstration on precision attachments, a demonstration on a new method of processing acrylic dentures and a three-visit denture technique.

The Department of Periodontology and Preventive Dentistry demonstrated splinting of mobile teeth, the practical use of fluoride gel, an assessment of topical treatment for acute ulcerative gingivitis, and, as usual, the hygienists gave an account of the various aspects of their work.

In the Clinical Research Laboratory the title "Is it all Tea-breaks and Sprague-Dawley Rats?" attracted more visitors than usual to brave the three flights of stone stairs in the old pathology block. Those who did so found the laboratory staff putting on what they described as a "normal day's work in the laboratory". Analyses were being carried out using the absorption spectrophotometer; acid production by streptococcus mutans was being measured in vitro and the EPACS (artificial mouth) was producing plaque to order.

In the Department of Oral Medicine and Pathology the findings of last year's oral survey were demonstrated and there was a provoca-

tive demonstration questioning the rôle of plaque as a precursor of dental caries. There was a further demonstration outlining the more recent views of aetiology and natural history of herpetic infections of the mouth.

The Casualty Department put on the now traditional diagnostic quiz and there was a most elegant tape-slide demonstration illustrating the principles of oral surgery procedures. The Photographic Department showed their 8mm. teaching films, and the X-ray Department had a demonstration of cranial radiography. As usual, there were operations being carried out in New Guy's House and there were demonstrations of advanced restorative dentistry and oral surgery in the clinic rooms.

The pre-prandial lecture, "My Year in Iran," on this occasion was given by Professor W. E. Herbert and he gave a most lucid and fascinating account of his year in that country as a Visiting Professor. Following the lecture the alumni wended their way, suitably overcoated, to the various hostelries in the neighbourhood to partake of the customary beer and sandwiches before returning to hear Professor R. A. Cawson deliver the traditional post-prandial lecture, "Cases you have sent".

The usual cariogenic tea was served in the Cafeteria in the East Wing and here the alumni continued their reminiscing before moving "up West" to the Park Lane Hotel for the Annual Dinner.

Clinical Day involves a lot of hard, extra work for many people. Not only do the demonstrators spend long hours preparing their offerings, but in addition the "Administration", the Medical Illustration Department, the Dental Photographic Department and the Maintenance Department all put in a tremendous amount of work behind the scenes to ensure that the day is a success.

M.N.N.

EAST KENT REUNION DINNER

will be held at

RICEMAN'S IN CANTERBURY

on

FRIDAY, 7th MAY,
7.0 p.m. for 7.30 p.m.

Anyone living in East Kent who did not receive the earlier correspondence and who would be interested, please contact J. B. Pond, 10, Granville Road, Walmer, Deal, Kent.

THE RESIDENTS' PLAY, 1971

Waiting for McAddle

or

Oh! What a Lovely Ward

The reviewer of the Guy's Hospital Annual Tribal Festival is as bound by convention as is the author. Unlike the professional critic, he may not devote four columns or more of a review of, say, "Hamlet" to a lengthy discourse on the true socialist meanings and implications of Brecht or the more obscure and esoteric aspects of the Traditions and Conventions of the Comedie Française and then deal with "Hamlet" in five lines. He is required to write about the play. People who haven't seen it like to know what it is about and possibly compare it with plays they *have* seen.

This year's play was seen not only by a packed house but also by an overflow audience in the Anatomy Theatre, who saw it on closed circuit TV!

The introduction was intriguing. To the background of Vaughan Williams' Fantasia on Greensleeves, a series of coloured slides of scenes on the hospital campus (and it is a campus), were displayed with a witty commentary by an unseen announcer, contrasting, for instance, a shot of sprawled sleeping students with the comment "hot-bed of Student Revolution, home of dedicated Maoists, immunologists and Trotskyites. . . ."

This cheery collage was followed by the appearance of the announcer who gave us dark warnings about the fact that formal censorship of the play had deprived us of the opportunity to be depraved and corrupted.

And then, the Play. The curtain rises on the first scene in the Director's Room of the Bloomfilled Clinic (what a fragrant possibility). Sir Gerald Fawn, Child Psychiatrist, V.S.O., N.B., is discovered seated pensively at a table. He smiles. At this stage the author scored many points by avoiding one of the most deadly pitfalls in Residents' Play writing, namely the play that starts with a central character seated alone and moving into a monologue about who he is and what he's up to. Actually, this just won't do and never has. Central characters have to be immediately recognisable, in which case who needs a monologue, and if it is needed, chronic disaster sets in. Anyway, the smiling Sir Gerald eschews this starter and receives the visiting Professor Runt, Intubologist and Sapient Parson ("there must be somebody in there, I'm not being too teleological about this"). He apologises for his tardiness ("stuck in the Tube") and soon we are in the maelstrom of Hospital Politics (the fantasy sensational; the

reality a non-event. Is Hell an eternal Committee Meeting?) The Superintendent has been replaced by a Prime Minister of Guy's and the job is up for gratis. Runt offers Fawn the Making of a President or rather the Selling of a President. Fawn, Preservative Party Member and Politician, is shaken and flattered—flattered by the offer but shaken by Runt's fiendish electronic listening devices. Whilst awaiting the arrival of allies McEel and Gauntze, they sing :

Aspirations

When your team is less than par
And the strains show, where you are
Then's the time for reflex action
PASS THE BUCK.

When your colleague, just the one,
Sends the under-21's,
You're just not placed to take the action
PASS THE BUCK.

When I'm in my Aston Martin
Driving down Park Lane at speed,
Every second brings me nearer
To another test meal feed.

When your bear is wearing thin
And the soldiers aren't of tin,
Paint your own bricks, turn it in, and
PASS THE BUCK.

When your tubes keep getting stuck
And you're aspirating muck,
Have a sherry, make it up and
PASS THE BUCK.

Travelling from the Bloomfield Clinic
To the dreaded H of P
All I think about is Reading
Rather than Psychiatry.

We are frightfully academic
In our own peculiar way
Time is not yet running out for us
Tho' our hairs are turning grey
STOP THE BUCK.

McEel enters in pursuit of exhausted Nurse, then Ralph Gauntze, gold stethoscope and all, supported by the wordless, hot-panted Aimee (Legs) McSkelton (leers). She carries his executive-style briefcase—contents, banknotes, gold patella hammer, gold proctoscope.

Gauntze, it appears, is to supply the funding for the Political Enterprise—this leads to his song :

A Taste of Money

Sing a song of new pence
Inflation comes with stealth
Heart sounds and the Stock Exchange
They keep me in good health.
Studying in Cambridge,
Colonel in the war,
Consultant and Directorships
One couldn't ask for more.

Sing a song of ten pence
New pence don't suffice.
Private hearts are better,
The difference is quite nice.
Masonic hearts beat louder
I hear the £.s.d.,
The coffers fill with guineas which
Is rather nice for me.

Sing a song of new pounds
Surtax growing steep.
Bought up Blewbury Manor
Converting pounds to sheep.
Thus the Inland Revenue
Cannot touch them now,
Money breeding money,
New pence from a cow.

Sing a song of money
Changing overnight,
D-Day won't affect me
Although you'd think it might.
For I've a handy syndrome
From which I've suffered much,
"Palpatio Auroris"
A chronic Midas touch.

All exit triumphant and jubilantly hopeful at the prospect of the Power-Money Alliance. From behind the curtains emerges Ronnie MacHeaf ("I'm not as out of touch as they usually make me out to be, you know. I know the baddies are plotting something, they usually do in Residents' Plays, but they reckoned without Super Ron—Bermondsey's answer to Batman and Breast-feeding"). Curtain. So far, so good.

Scene Two, the Colonnade (the Ypres Salient of many a play), where enters the magnificent figure of Sister Fix with newly-arrived

"If Women's Lib. could see me now."

PTS nurses. She shows them round. "This is the Colonnade, named in memory of Sir Arbuthnot Lane, a great Guy's surgeon, who did unbelievable things to the Colon." Exit les jeunes filles and enter surgeons Rex Sorrie and Guy Heartburn. Guy comes straight to the point and explains with horror in his voice that Fawn is being put up for Prime Minister of Guy's. Astounded, Rex listens and outlines the requirements of the post.

"A really brilliant, dedicated man, brilliant at his work and administration, popular, witty—a magnetic personality."

Guy acknowledges this description of himself and offers to be a rival candidate. But MacAddle has offered to help them and Ronnie MacHeaf appears in Super Ron outfit. But we have left the songs behind—viz.:

No Strings

We're Guy's Girls and new here today
We're sure we'll enjoy our stay
Our dresses are long and fearfully tight
But if we don't breathe, we may well be all right.

I'm Sister Fix, I'm the Queen of the Night
Always dependable, and always right.
A model nurse when on my midnight patrol
I exercise gently total control.

I'm Bunty Fitz-Perfectly of Benenden fame;
Mum's got the money, and Dad's got the name.
No fishing or shooting at Guy's tho', so far,
But hunting—there's plenty in the Students' Bar!

Iona Boddy—I think that's quite clear
I go in at the waist, and out about here
Mummy has warned me to keep myself chaste . . .
It really does seem such a terrible waste!

They called me Melaena, I don't know quite why
I'm tall, dark and handsome, and terribly shy.
When Housemen talk to me, I swoon right away
Oh I **do** wish I **could** think of something to say!

and

Why, Hello!

Hello Rex! Hello Guy!
My word, you're looking absolutely spiffing
Hello Guy! Hello Rex!
Your manners are so absolutely ripping!
Our operating sessions are becoming quite a laugh
Our mutual admiration just sends the nursing staff
And Rex, you're always round about to take a photograph.
Hello Guy! Hello Rex! Hello Guy!

Hello Guy! Hello Rex!
I wish I had your touch with woody goitre
Hello Rex! Hello Guy!
I can't resist a rectal reconnoitre.
Our politics have taken some rather dangerous swerves
I've got a healthy interest in ample female curves
And I wouldn't put it past you to cut recurrent nerves,
Hello Rex! Hello Guy! Hello Rex!

Hello Rex! Hello Guy!
Queen's Square has really made us quite imprudent
Hello Guy! Hello Rex!
Don't say you've failed another female student?
Our textbook's quite sensational, we never put it down
The dressers never read it, it makes their faces frown
So we tell them please come back again when green leaves turn
[to brown!
Hello Rex! Hello Guy! Hello Rex!
We are the smoothest surgeons that Guy's has ever seen
We make the other surgeons here look absolutely green,
And we clear up after Randy—when he's gone and been . . .
Hello Rex! Hello Guy! Hello Rex!

And for that matter, Ronnie MacHeaf's song:

What Have I Done Ron?

Up in the children's ward,
Look out! He might go "Boo",
Is a suede-shoed, glass-eyed monster
And I think that you know who
He's who he is,
And what he is,
It needs no explanation,
And his world revolves around a red carnation.

He wears an old blue suit
And a dirty tie to match,
But when it comes to treating kids
Not many are a patch
On him, it's not a whim,
But his very motivation
And his world revolves around a red carnation.

The heights of little girls he finds
Is one of nature's joys,
But even this cannot compare
With the lengths of little boys.
Oh what a bore, he's looking for
New ways of mensuration
And his world revolves around a red carnation.

He finds delight in female form,
A breast as soft as silk,
And recommends the lukewarm taste
Of human mothers' milk.
It's clean and sweet, goes down a treat
And needs no mastication,
And his world revolves around a red carnation.

By now the plot is established, two rival parties for the Prime Ministership. The curtain falls on Act One and there is the interval—time to think things out.

Act Two is prefaced by an amusing Prologue in which This Week's Good Cause is stated by Lord Sea of Beachy Head on behalf of the G.M.C. "We're all getting on a bit at the G.M.C., you know. There aren't many of us under 65 and the winters are getting colder. Now all we're asking is that you should start paying again for the registration you've bought already—just think, for only £2 a year—so far—we'll allow you to stay on the Medical Register."

The First Scene—Guy's Switchboard.

"Hello, Switch—can I help you?"

Darkness, save for the glow of switchboard lights. A hilarious series of recorded switchboard exchanges. The lights go up, revealing three switchboard operators in the author's words, "bizarrely dressed." The reviewer should point out that this is, after all, the age of unisex clothing and anyway Mary Quant's brother is a member of the cast. The operators, Atilla, Blossom and Fudge, are supervised by their chief Barquin Darkly—and who better than this quartet to sing the "Round the Hospital Song" :

Gossip Song

We're the boys who work on the board
Girl-friends we find we cannot afford,
Barquin he rules us, he drives us insane
Plug me in — Give me a line — and ring me again.

Dial O for switchboard, we're always around
With lights all a-flashing and that sweet bleeping sound.
For an outside call—go ahead, you are through!
In case of emergency, dial 222.

On nights it is lonely, few give us a ring.
Some Housemen are busy inside the West Wing;
Others are always in the Residents' Bar
Orthopods, Anaesthetists with their Registrars.

Now Batch has retired, the Commander is boss.
We wonder if this will make him slightly less cross.
He's slowly taking over the Surgical Block
And arrives in a car that competes with Lord Brock.

Professor Butterfield is going away
An Academic post he will fill so they say,
Making all hairy students toe the line.
A Sheriff of Nottingham—that'll suit him fine.

Nephrology for Nurses is a very fine book
Cameron and Russell—what a long time they took.
It's a pity that for students it really was meant
If it sells a lot of copies, it'll help pay Stewart's rent.

To drive a red Aston Martin on Consultant's pay
Is quite an achievement, some people say
I wonder how he does it—his patients aren't so ill
—Performing operations when forgetting the Pill.

Enter McEel, nonplussed at first but warming to his theme. He appeals to all for their help in assuming the victory of his side in the coming election. Having gained their co-operation he sings :

The Registrar's Lament

I'm the oldest Registrar that Guy's has ever had
And I think I really know my way around.
But I'm looking at the jobs, and moving off quite soon,
So spread the word—my opinion's very sound.

Oh the sound of pints of beer being poured is calling me away
To the Residents' Bar, till I have had my fill.
Oh I'll drink a pint, I'll drink two pints, and maybe three or four,
Has anyone been here longer than McEel ?

There are grey hairs on my head and wrinkles in my skin,
So whilst in Endocrines I took a Pill
Every day for twenty-one, and then for seven days again
I was hoping to give all the girls a thrill.

To my great disappointment there was little change at all.
The transformation simply wouldn't come.
Not the oestrogen, testosterone, or any other drug
Could improve on me—already best of all.

I've done all the medical firms there are to do at Guy's
So my grip on medical matters is quite tight.
I've been doing double take-ins while Pete Harris was away,
What a shame I won't get home again tonight.

He exits and the switchboard operators return to their work as the background noises and the lights fade into Scene Two (Matron's Office), where are found Male Charge Nurse MacCavity and Dolly Mixture, Housewoman and Political Activist.

Dr. Mixture, keen and ardent, politically and in all sorts of ways, as one might say, attempts to reassure the ambivalent MacCavity—they sing their love song—combining traditional romantic lyricism with skin flick eroticism :

Nidification

My nest in the East Wing
And mine in the West Wing
Are both lacking something
That something is you.
So let us invest in
A nest we can rest in,
To test the suggestion
That I'm made for you.

Titivation
Titillation
Motivation-liberation
Insinuation-Consummation
Culmination-Procreation.

When we have our family
Together we'll never be
The future is hard to see
For who'll stay at home.
If we're both ambitious,
Then who'll wash the dishes ?
Our marriage propitious
Will fail, and we'll roam.

So don't be depressed in
No just be my guest in
I'll be at my best in
The West/East Wing with me.

They are disturbed by the entrance of Sister Fix and Guy Heartburn, the lovers hide behind the reception desk. They overhear the meeting. Actually, Sister Fix is the Chapter Leader of the Women's Lib. and implores Guy to withdraw his candidature ("there's a lot to be said for withdrawal, you know.") And seeking no doubt to pre-empt this she goes into a strip. Heartburn refuses to stand down and Fix calls in her PTS nurses, revealing their remarkable potential as supporters of Women's Lib. with a song of Revolution :

A Song of Revolution

Oh, we're going to have Revolution :
The biggest there ever has been !
We will blow up the Houses of Parliament
Then go out and shoot at the Queen !

Oh! Sing Tooral-ay-ooralay-ANARCHY!
Sing tooral-ay-ooralay-BLOOD!
If you don't join in our Revolution
We can tell you your name will be mud!

Oh, we're going to have Revolution
Shall we hold it in April or May?
Shall we start in the morning or afternoon?
I do hope it'll be a fine day!

Oh, Hurrah for the bombs and the barricades!
Such amusements we always enjoy!
Hurrah for these small simple pleasures—
It's a grand outdoor life for a boy!

Oh, we're going to have Revolution!
We will build barricades in the street!
We will shout and throw stones at policemen!
What a grand intellectual treat!

STILL waiting for McAddle.

All depart, leaving Dolly Mixture and the detumescent MacCavity astonished but "cramped and content".

Act Three, Scene One is the Park—it is Election Day and Psephologist Dr. Pills (Radiologist and Censor) is counting the votes and interpreting the swings. It is, it seems—"a damned close run thing", Pills' comments are penetrating, confusing and as optimistically pessimistic as these things usually are. All still wait for McAddle to stand up and be counted.

Pills halts the proceedings, introduces himself and explains just what it is that he does—in his song :

Nobody Knows De Trouble Obscene

You can read an X-ray,
Repeat an X-ray,
Even leave-in-the-X-ray-Department an X-ray,
Request an X-ray,
Inspect an X-ray,
Even remove-before-being-reported-on an X-ray,
But — but but but
To **take** an X-ray
You gotta be a Ra-
Diologist.
For a jolly good screen
Of the frankly obscene
You've gotta be a Radiologist.

You can light a cigar,
Roll a cigar,
Even put-to-your-ear-and-listen-to a cigar,
Sniff a cigar,
Chew a cigar,
Even dangle-between-your-lips a cigar,
But — but but but
To **smoke** a cigar
You've gotta be a Ra-
Diologist.
For a jolly good smoke
Among friendly folk
You've gotta be a Radiologist.

You can write a play,
Produce a play,
Even run-around-behind-the-scenes of a play,
Read a play,
Love a play,
Even write-a-very-nice-review of a play,
But — but but but
To **Censor** a play
You've gotta be a Ra-
Diologist.
For a jolly good screen
Of the frankly obscene
You've gotta be a Radiologist.

His hearers, however, grow impatient. Swings and trends are all very well but what *is* the result of the Election? Pills declares a draw Horrors. Charge Nurse MacCavity discovers that the York Clinic Ballot Box is missing. The solution is clear, all must now go to the York Clinic to see just what the result may be.

No prizes for discovering that the final scene is on Mount Olympus—the sixth floor of York Clinic. On a mound is a Throne. All enter and stand at the base of the mound. In silence they wait, gazing upwards, expectant and hushed with hope and self-interested adoration, looking for the arrival of Shane, the man who rides into town on a white horse, sorts it all out and rides away, or whatever is their personal fantasy.

To the opening bars of Strauss' "Also Sprach Zarathustra" overture, he enters in a pink and gold haze in clouds of smoke. Snaffle-Shark descends from above and is greeted by the waiting crowd. He grets them, benign and magnanimously smiling and courteously. He receives Fawn's appeal for the critical votes and mounts the steps to the Throne with easy and assured stride. He sits, hitches up his trousers, adjusts his glasses and reminisces: "This reminds me of an occasion during the war—in Bomber Command . . . a very interesting case of . . . an unfortunate experience with a loaf of bread . . . must remain absolutely confidential . . . possessive and moody young man . . . ate her husband on the wedding night . . . one of the most beautiful women I've ever seen . . . poignant young woman . . . of course I was right . . . son of the Maharajah . . . my accident . . . this seat is meant for Flamingo. . . ."

A testy interruption from Heartburn stops the stroll down Memory Lane. He appeals to David to give the decision. But first David sings:

Get Staphed

On Old Olympus' Towering Top
A Hun And Grecian Viewed A Hop.
The Greek was drunk the Hun was not,
Their argument grew long and hot.
That Hun and Greek could not agree
—And so, of course, they sent for me.

Is your Ego getting tatty?
Is your Psyche wearing thin?
Are your Id and Supergo far from nice?
Then with drugs and chat and ECT,
A weekly sight of little me,
We'll have you really well in just a trice.

"As for you, Dr. MacHeaf, a lifetime's supply of red carnations."

The Maharajah of Sikkim,
He found his powers growing dim.
The cure he sought for his dejection
A Staphrodisiac injection.
While he could still afford my fee
—This charming fellow sent for me.

A female rapist name of Kay,
Caused chaos at the B.M.A.
Her handling of the final motion
Closed the committee in commotion.
As soon as they had finished tea
—This poignant girl was sent to me.

Defecting dancer Tackitoff,
Developed a neurotic cough.
He nearly ruined his entrechat
Practising high kicks at the bar.
When offered Sargant, he said with glee
—It must be Snaffle-Shark for me!

A Member of the House of Lords
Tied up his wife with leather cords.
And when she told him she would sue,
Just shouted—"chacun a son gout!"
So as not to ruin the family tree
—They rather promptly sent for me.

He delivers the judgment.

—to Fawn: (Land of Hope and Glory)—the Prime Ministership.

—Fix : Housekeeper to the P.M.

—Heartburn: the Tower Block for his Persian Private Patients.

—Runt : The Ministership of Intubation.

—McEel : The care of the Nurses' Sick Bay.

—Pills : Reward censored.

—MacHeaf : A clinic all of his own and a lifetime's supply of red carnations.

—Sorrie : Membership of the Royal Photographic Society and Mastership of Many a College of Surgeons.

—Mr. Darkly : Minister of Communications.

—Dolly Mixture : her love.

—The Nurses : the run of the East Wing.

—Gauntze—Chancellor of the Exchequer.

In other words—treats for all and a lead into curtains, the end and the Final Chorus—a superb medley—Oh! What a Lovely Ward—hospital based renditions of the First World War songs immortalised in Oh! What a Lovely War!

This Medley bears re-reading. It contains fair comment on hospital life—not just Guy's Hospital life—and ends with the nostalgia of "And when they ask us how much work this play has been . . ."

In one of the most comic books in the English language—"The Diary of a Nobody"—there is a pretty dialogue between Mr. Pooter

and a would-be actor friend of Pooter's irrepressible son Lupin. The actor has just finished an interminable series of after-dinner invitations, ending with one of Henry Irving.

Poor Mr. Pooter, bewildered by it all, attempts to make a witty remark to the actor, saying "but, after all, without the original there can be no imitation." Since the actor has been claiming that this imitation is superior to the original the remark is not well received. Here, in a sense, is the existential dilemma of the Residents' Player—are the imitations better or worse than the originals? The author may put as much as he is able of his own wit, observation and appreciation of the characters into his writing but it is up to the actors to make something out of them to make them more than marionettes.

This is the central test of a Residents' Play. Oddly enough it doesn't quite end there because sometimes a representation of an original transcends it/him and becomes a comic creation in its own right. But to return to this play. In every play one characterisation stands out. For my money, David Briggs as Ronnie MacHeaf struck just the right note, containing the exact mixture of accuracy and affectionate caricature. On the whole, the standard was high : Nicholas Howell's Fawn was visually and in character correct but lacked caricature. Runt and Gauntze were well observed, but unhappily David Thomas missed the real physical presence of the latter. Rex Sorrie (Malcolm Hillier) was a cheery chappie and Guy Heartburn (James Pitt-Payne) was the best I've seen since 1948, when I first saw a Residents' Play.

Snaffle-Shark (Andrew Seal) was right, dapper, perky and bright but missed the bravura of the original.

In any good play there is a show stopper. This year's was provided by Sister Fix's striptease. I fancy that Michael Simpson must have put in a good deal of postgraduate study in London Strip Clubs. His bumps and grinds were perfect.

The singing was good, in one case exceptionally good—I refer to James Pitt-Payne's singing in the "Oh! What a Lovely Ward" medley. A fine tenor. He took many encores.

The music was sprightly, melodic and pleasant, though I'd fault the Song of Revolution as being too much for the performers—no soul sisters, I fear. The musicians I thought very talented; quite apart from the play music I greatly enjoyed their interval music—including a super playing of a great standard, "Take the A Train".

So it all adds up to bouquets for Author/Director Michael Simpson, Producer Piers Reinhold, Lyricists (many) and Composer Michael Lavelle. One or two carping voices remarked on shortage of counterplots. The excessive counterplotting in Residents' Plays I find a great drag. That's an idea : What about the 1972 play in Drag? Myra Breckinridge, hurry up and qualify.

J.H.W.

Oh! What a Lovely Ward! Medley

Oh! Oh! Oh! it's a lovely Ward!
Who wouldn't be a doctor, eh?
Oh! It's a shame to take the pay;
As soon as the switchboard has rung
We feel just as heavy as lead
But we never get up till the Staff Nurse
Brings our breakfast up to bed.

Oh! Oh! Oh! what a lovely ward!
What's there to fear about disease
When we've got doctors such as these?
Form fours, right turn,
How shall we spend the money we earn?
Oh! Oh! Oh! it's a lovely ward!

Up to your waist in water,
Up to your eyes in sshh . . .
Using the kind of language
That makes the Sister spit.
Who wouldn't work all night, then,
That's what we all enquire?
Don't we pity the poor civilian
Sitting beside the fire.

Oh we don't want to bleep you,
  But we think you ought to come
For your nurse and your patient
  Are not having fun
We both want you and miss you
  And with all our might and main
We shall cheer you, thank you, kiss you
  When you come here again.

The National Health Service needs attention
The outlook isn't healthy, you'll admit
But I've got a perfect dream of a new recruiting scheme,
Which I think is absolutely it.
If only more Guy's girls would do as I do
I believe that we could manage it alone
  —For all suitors I just spurn 'em,
    But the doctor and the surgeon
  —I've a lot of medical manpower of my own!

On Sunday I walk out with a Houseman,
On Monday it's a super Registrar;
On Tuesday, hell-bent, with a lively student,
On Wednesday, in the Residents' Bar.
On Thursday I go out with **that** Scotsman,
On Friday I take on the Take-in Team;
But on Saturday I'm willing if you'll only take the shilling
To make a Doc' of any one of you.

The National Health Service needs attention.
The outlook isn't healthy you'll admit.
Which I think is absolutely it.
If only more **Guys** would do as I do,
I believe we could manage it alone.
—All advances I reverse, save from Sister and from Nurse.
—Now recruits are queuing up—see what I mean?

On Sunday I smile at a young Staff Nurse
On Monday it's a bright young P.T.S.
On Tuesday a Number 7 is really 7th heaven;
On Wednesday she wears strings.
On Thursday I have sherry with the Matron,
On Friday, Night Sister's my delight;
But on Saturday I'm willing, if you'll only take the shilling,
To make a nurse of any one of you.

Hush! here comes a Bed Pan!
Hush, here comes a Bed Pan!
Now you doctor men get down those stairs
Down in your little rooms and say your prayers.
Hush—here comes a Bed Pan!
And it's heading right for you;
And you'll see all the wonders of no-man's-land
If the Bed Pan hits you.

One House Officer jumped right over another H.O's. back,
And another House Officer jumped right over that other H.O's. back
A third H.O. jumped right over the two others H.O's. backs
And a Senior House Officer jumped right over all the other House Officers' backs.

They were only playing leapfrog,
They were only playing leapfrog,
They were only playing leapfrog,

When one H.O. jumped right over another H.O's. back.
You've got to wear silk underwear to be a Registrar.
If you went to Epsom College, boy, I'm sure that you'll go far.
Brush your teeth just twice a week, and laugh at the Old Man's jokes,
And the next H.O. jumped right over the other H.Os'. backs.

When this bloody ward round's over,
I'll take off my shoes with glee.
When I get my next weekend off
Oh! how happy I shall be!
No more business rounds on Sundays!
No more Pink Sheets haunting me!
No more writing up of Trips then;
Then, at least I will be free!

And when they ask us, how much work this play has been,
Oh, we'll never tell them, no, we'll never tell them.
We'd spent each day in some café
And fought wild nurses night and day
'Twas the cushiest job we ever had.
And when they ask us, and they're certainly going to ask us
The reason why we always do a Residents' Play,
Oh! We'll never tell them, no we'll never tell them—
There was a reason, but darned if we knew why.

Debating Society

Thursday, 25th February

The motion before the House in this, the first meeting of the Guy's Hospital Debating Society since 1967, was "This House believes that the Labour Government, 1964-70, was a qualified success". The proposer, Mr. L. Read, told us that this country had been in a state of decline since 1870, and of the social and economic effects this had on the community. He enumerated measures taken during the Ministry directed at reversing the situation. These included measures affecting the economy, but major emphasis was placed on the social measures taken.

In opposing the motion, Mr. G. Bernays told us that the real power of government in the period 1964-70 lay in the Trades Unions. He then attacked the government policies on defence and foreign policy, quoting as examples of their ineptitude the cancellations of the TSR2 and the F1-11A military aircraft, and their lack of vigorous action regarding Rhodesia.

Miss Diane Plamping, seconding the motion, said she failed to see how the House could not carry the motion as the ministry must have appealed to the one per cent of Socialists in the House and the 99 per cent of Tories who must have seen it as a very conservative ministry responsible for the highest unemployment since the war, the introduction for the first time of National Health charges and such-like un-Socialist measures.

Mr. F. Moorhouse, seconding for the opposition, attacked the motion and asked the House to read the word "qualified" in the sense of successfully negotiating a period of apprenticeship. This, he said, they failed to do.

The motion was then opened to the House and, after the summing up by the two main speakers, a vote was taken. The result was eighteen votes for the motion, eighteen votes against and three abstentions, and it was decided to declare an amicable tie.

The committee which has been formed is of entirely unelected members and we would welcome support from anyone in the hospital. We would also like to thank Professor Macdonald, who has kindly agreed to become our honorary president, for chairing this meeting.

P. N. Read.

mps

medical protection society est. 1892

Students!
Arrange membership now.
Full benefit immediately
you qualify.
Pay later at no extra cost.

Over 50,000 members enjoy

- unlimited advice
- unlimited legal aid
- unlimited indemnity

Full details from
Secretary:
Dr. H.A. Constable, Head Office
50 Hallam Street, London, W1N 6DE
Telephone: 01-580 9241
or
Regional Secretary:
Dr. P.G.T. Ford, Regional Office,
30 Park Square, Leeds 1
Telephone: 0532 42115-6

NURSING SECTION

Salmon—Is It Too Late?

How encouraging it was to read, in the Nursing Press recently, the article decrying the Salmon structure for nursing. What made it even better was the fact that the article was written not by a nurse, but by a doctor. What a pity, however, that he did not write it three years ago.

The statements made in the article were very similar to those expressed by many nurses for some time, including the one which said that criticism in the Profession has been strongly repressed. Of course the people who have been in the greatest opposition are the ward Sisters. This is not surprising when one considers that it is they who are to be more or less eliminated. What nobody beyond the level of a ward sister appears to understand, is that there are actually those amongst us who wish to nurse patients, and only those who are working constantly in that capacity are, in fact, competent to do so. Those in the Profession who have reached higher status will often describe the weight of responsibility which they carry, but despite this they are not directly responsible for thirty patients, and they do disappear like "snowflakes in the desert" whenever an emergency occurs.

It is difficult to envisage a way in which the implementation of this scheme can now be stopped. We have never, of course, had the report of the Pilot Schemes published for perusal, so great was the desire for power amongst certain people. This, of course, is atrocious. It would, however, be difficult to demote those who are already appointed. Why is it though, that a halt cannot be called, in order that full appraisal could be made? Why not adopt the idea suggested in the article and organise a ballot? Instead of this being arranged through the Royal College of Nursing, though, it would be conducted in individual hospitals. Otherwise all those who have so little faith in their professional organisation that they have not joined, would be denied the opportunity of voting! It was, incidentally, interesting to note the reaction of the College to this suggestion. Only a nurse educated in the true authoritarian manner could have replied to the Press in the way that the official statement was worded.

Why should the Profession accept a system which to a large number is anathema? Why should we cast aside the standards which we have always thought essential for the well-being and safety of the patients? Why should we follow blindly the system adopted in America?

It is surely time that this apathy was overcome. Does not anyone care sufficiently any longer? All those number sevens should be returned to the wards where they belong, and pursue the essential task of imparting their experience to the younger generation. At the same time they should be paid accordingly, in order that they do not feel left behind in the rat-race.

It seems unfortunate that we have to stand aside and watch our own profession decline in order to satisfy the whims of mere politicians.

Your friendly local bank.

You've probably noticed our new sign a lot lately when you go to work, or shopping or visiting.

That's because we've been rather busy putting up somewhat more than 3,600 new signs. More than any other bank.

That makes us more local: we're never far away wherever you may go throughout England and Wales.

We have more customers too—more friends, that is. Which means more practice solving money problems. And if you haven't got any, now's the time to come and see us. Prevention is better than cure.

And if, by the way, you haven't noticed our new sign, do have a look out for it.

National Westminster Bank

Simply there to help

CORRESPONDENCE

Salmon

SIR,—The *Gazette* of 16th January has been delayed by the postal strike and so I have only just seen Mrs. Hallam's vitriolic comments on my earlier letter.

I was replying to the points made in an article and not writing a full report on Salmon in Harrogate and may, therefore, have over-simplified my comments. The point I was stressing was that with Salmon each Nursing Officer has clear lines of authority, whereas pre-Salmon there were uncertainties about who was responsible for what among a multitude of Administrative Sisters, Assistant Matrons, Deputy Matrons and Matrons in each Group. Mrs. Hallam asks what sort of progress is this. One advance which she tacitly admits is that the nurses are now responsible to the Board or Hospital Management Committee (and why, incidentally, should the latter be less happy?). The nurses now have a voice on committees, which they did not have before when their opinions could usually be made known only at second hand through the Group or Board's Secretary. Salmon and wastage are not necessarily cause and effect. Again, I can quote only my own Group, but here recruitment continues and we still are each year bringing additional wards into use.

I made no mention that I enjoyed being a Chief Nursing Officer. That is beside the point, but I agree wholeheartedly with some of the changes that I am now able to implement. How Salmon is implemented will vary from Group to Group just as the structure and practice of nurse administration varied before Salmon and there is a danger that Salmon is now being blamed unjustly on the basis of *post hoc ergo propter hoc.*

One final point, I can assure Mrs. Hallam that I am not glued to my swivel chair. Having been the Group Matron for five years before being appointed Chief Nursing Officer, I was already in the habit of visiting the hospitals frequently and meeting all grades of staff and this I have continued to do and am fully aware of our many problems. It may surprise Mrs. Hallam to know that before sending my previous letter, it, plus the article which provoked me to write, was given to the Nursing Officers for discussion and was sent with their encouragement.

Yours sincerely,
MOLLY FARNSWORTH,
Chief Nursing Officer.

Harrogate and District General Hospital,
Harrogate.

Ladies' Association

SIR,—The Annual General Meeting of the Ladies' Association is to be held in the Medical School on Wednesday, 5th May, at 2.30 p.m. Mr. J. S. Batchelor, F.R.C.S., has kindly consented to take the Chair, and Captain T. E. Podger, C.B.E., R.N., recently Senior Probation Officer at the Central Criminal Court, will be the guest speaker. His subject is "Youth in Difficulties".

Members and friends and the nursing staff will be most welcome.

Yours faithfully,
L. F. W. SALMON,
Hon. Secretary.

Guy's Hospital Ladies' Association,
Guy's Hospital,
London, S.E.1.

Come home—otherwise we won't forgive you

SIR,—I would like to endorse the views of Graham Hey and J. E. Davies regarding the Guy's R.F.C. (7th and 21st November, 1970). I also remember a number of years ago when the club was going through a lean season, and the pessimists were suggesting weakening the fixture list. Fortunately this was not done, and subsequently the club did well. If there are a

number of Guy's graduates playing rugby for other clubs in and around London, they obviously should be contacted and urged to play for their Alma Mater. In fact, it is hard for me to understand why they are not playing for Guy's at this time.

There is another point I would like to emphasise. Those that select the incoming students have a responsibility in keeping up the high standards of athletics at Guy's Hospital. No one will argue that the main purpose of the Medical and Dental Schools is to train young men and women in being good doctors and dentists, but experience has shown time and time again that being a top-rate doctor, dentist or scientist is certainly compatible with being a good athlete. Obviously, recently the Selection Committee for the Medical and Dental Schools at Guy's has not taken this into consideration as I believe it once did. Possibly I may be unaware of other factors in the selection of students, being several thousand miles away.

As an old Guy's man, I do want to express my appreciation to Graham Hey and J. E. Davies for their letters and ideas regarding this problem.

Yours faithfully,

ROBERT G. WALTON, M.D.

1700 McHenry Village Way,
Modesto, California 95350.

Guy's Part of the University ?

SIR,—The reluctance of the majority to express their opinion, even merely by voting, is well documented and by no means confined to Guy's, but when the elected representatives fail to represent their electorate, this must not be tolerated. At the A.G.M. of the Students' Club on 16th March, several of the newly-elected representatives did not even attend. At this meeting Tony Attwood drew attention to the annual meeting of the Assembly of Councils, the largest, most powerful student assembly of the University, on 18th March. Guy's was allowed three representatives from the Students' Club and one from the Sports Council. None attended.

During the past year the Student Representatives' Council, to which Guy's is supposed to send three members, but usually sends none, has passed resolutions condemning the Government's Industrial Relations Bill and offering finance to oppose it and condemning the political system of South Africa. What was the Guys view when this was done on our behalf? The university is not hopelessly saturated with "lefties" as when one of us told the S.R.C. to put its own house in order instead of interfering with party politics and the politics of other countries, he was not shouted down by Communist sabateurs, but greeted with widespread cheers and applause. Furthermore, what was the attitude of Guy's when the S.R.C. proposed Paul Koch, an individual of notorious repute, for honorary life membership of the university? Fortunately, many of the Assembly of Councils recognised his name, and the nomination was rejected by a large majority.

We can take little consolation in the fact that failure of representation is not limited to Guy's. Of the 300 people eligible to vote, only 121 did so, and when someone from the floor discovered that the necessary quorum of 150 were not present, he demanded that the meeting be closed. However, this did not nullify the completed elections and motions, and the only motion left undebated was one which would have made the facilities of the union available to nurses, physiotherapists, etc.

Finally we would like to plead that in future, when we elect our own student president, we should not be asked to "sign a blank cheque", but that the candidates' record and intentions should be presented to the electorate.

Apathy is not a non-event. It is a charter for extremists to rule unopposed, If the silent majority were to become less silent, then the lunatic fringe would sink into oblivion.

Yours faithfully,

PAUL HEWISH (Secretary of U.L. Judo Club).
BARRY J. M. JONES (Vice-President-elect U.L. Sports Council) and Secretary U.L. Canoe Club.

East Wing,
Guy's Hospital,
London, S.E.1.

SPORT

RUGBY

CUP REFLECTIONS

Ten years ago, Mr. J. S. Batchelor took over the Presidency from the then Mr. Hedley Atkins, and the Hospital's 1st XV, under the captaincy of Terence English, won the Hospitals' Cup after twelve seasons without success in the competition. The cup was again won in 1967 by a side led by John Davies. For three further seasons, 1968-69-70, Guy's have been runners-up. Now in the season that Dr. D. Stafford-Clark replaces Mr. J. S. Batchelor, the Hospital has again recaptured the cup.

It would not be correct to interpret our fortunes, and reverses in terms of the Presidency, for the club has been well served in this office by the giving of unselfish encouragement. A new impetus has directed Guy's towards the Final in the past five seasons. This factor has been the coaching of Dr. Hugh Burry. In spite of his obvious disappointment in not producing a cup-winning side during seasons when he had pushed the club's rugby to a very high standard, his determination to persevere has been a challenge to members of the club and a measure of the means by which this year's success was obtained. By his persuasion, present and estranged members of the club were induced to train regularly, and in particular on every Sunday morning for eight weeks. In this way a team was moulded which made the best use of available talents and which sensed understanding and a desire to win. This achievement must not be allowed to overshadow the very difficult rôle played by the captain, Tony Fallowfield. He accepted his position for a season in which a shortage of mature players has been associated with many heavy defeats in Saturday matches. These setbacks could have so shaken morale that any extra effort for the cup competition may not have been forthcoming. In fact, by his clear unwillingness to give up and the tenacity of his own efforts in every game and training session, he achieved a sustained response from most members of his club. With this background, the foundations of our success were laid. Whilst not denying that within each round, certain players played a more dominant rôle, and we were fortunate in this respect in having the services of C. Thorburn, C. Neville, J. Ross and J. Novak, who are normally playing with other clubs, it is a fair conclusion that cup matches are won by combined fifteens, who make few bad mistakes and who grasp scoring opportunities. For Guy's this season, one felt that in every round, fifteen players were supporting each other in achieving this end, and it was interesting that the scoring was shared between the more experienced and the younger members of the team. Hence, after four attempts in succession, the Final was won and it was pleasing to note that the Hospital still had many followers prepared to lend support on the day.

Having made these comments, one cannot avoid reflecting on the rest of the season and the marked contrast of our success in the cup competition and the gloomy record of Saturday matches. The cup competition always arouses an interest and spirit over and above club games, and there is a customary tightening up in team training and discipline as well as an increased willingness of individual endeavour. The same interest and spirit made available some of the experienced players still at the Hospital, but playing for other clubs or in temporary retirement. With teams for Saturday games having a shortage of well-tried talent, there can be no doubt that this additional experience counted in the cup games. But the overall rugby season has changed, and is changing. First-class rugby now demands a high standard of fitness, attention to team skills and the availability of experienced players. Whilst the Inter-Hospitals' Cup matches are still fiercely competitive, it has to be recognised that all the sides involved have had difficulties at the hands of first-class clubs, and that we are not the only Hospital unable to retain the services of more talented players. Finally, the cup competition, also in con-

trast to the rest of the season, draws a large measure of support, but only a few faithful supporters are drawn to Honor Oak Park. All those truths come home to the club in a pitiful performance of rugby-like activity, in defeat by the Old Alleynians on the following Saturday!

These problems have to be faced not just by Guy's Hospital Rugby Club, but by all the Hospitals' Rugby Clubs. Undoubtedly, the cup competition will continue and rightly so. Apart from the University match, it is the oldest competition of its kind and still maintains its vitality. But there are going to be larger and tougher knock-outs and leagues for all clubs in the future. A United Hospitals' Club has been suggested. Could this club be centralised and organised efficiently to provide the right spirit and facilities to attract players of international and county standards, and also fairly assess the aspirations of younger unknowns?—M. Danford or J. R. P. Williams for full back? Those should be serious thoughts for the close season.

I. A. BAKER.

JUNIOR HOSPITALS' CUP SEMI-FINAL

Played 24th February.

Guy's 16, Bart's 6.

This game, played at H.O.P., opened with both sides getting equal share of the ball and providing some good spectator rugby. With play well into the first half, Guy's opened the scoring with a penalty goal by Tony Mellor. This score was further increased before half-time, when after a forward rush under he leadership of Tim Higenbottam, Chris Bates went over for a try, and Mellor converted. Bart's started the second half well with some fine kicking from skipper Peter Evans keeping play in their opponents' half. Good tackling from the Guy's three-quarters prevented Bart's from scoring. Gradually Guy's gained the upper hand and increased their lead by another try from Bates following a five yard scrum. Unfortunately Bart's lost one of their players through injury—but undeterred they managed to reduce the arrears with an unconverted try from Gordon Brain and a penalty goal from their skipper. Guy's soon consolidated matters with a try from Ken Rigg who scored after following up some fine tactical kicking by Peter Matthews. Mellor again converted. Guy's remained in control until full-time with the backs running well especially Paul Board on the left wing.

D.G.L.

HOCKEY

JUNIOR HOSPITALS' CUP SEMI-FINAL

GUY'S v. BART'S

Won 1—0.

Guy's are through to the final of the Junior Cup after two tremendous wins by default and now this win at Chislehurst was sweet revenge for a defeat in almost identical circumstances last year. Guy's managed to field their strongest side but were kept champing at the bit by a tardy Bart's side that were far from keen to get the game started.

Referee R. Fell at last managed to organise a bully-off and a keenly fought first half failed to produce any goals. Although both sides shared the ball fairly evenly, Guy's failed to capitalise on several scoring chances whilst Cottingham, in the Guy's goal, remained untested.

Our early arrival at the game and consequent short corner practice paid off when Sparrow managed to stop cleanly a hard hit-out and Fitten's shot went into the net off the goal-keeper.

Bart's gave us a few hair-raising moments, particularly when their talented inside-right was allowed to get going; our defence, however, played extremely intelligently. Cooper, at the other end, scored what looked a very good goal but it was disallowed, and Guy's had to hold out for a further fifteen minutes.

The inside forwards in particular had run themselves into the ground and the last few minutes vere very scrappy due to sheer fatigue. If we manage to play at our best for the full 70 minutes in the final, we should have the Cup back at Guy's this season.

Team: J. Cottingham, R. Fitten, G. Chasak, C. Crawshaw, P. Duckworth, A. Holland, B. Martindale (capt.), G. Sparrow, I. Cooper, B. Brownlee, B. Jones.

B.V.M.

TABLE-TENNIS CLUB

MIXED DOUBLES, 1971

On Thursday, 11th February, a new championship tournament was played at Guy's. This was the Mixed Doubles Championship, 1971. It was such a success that this type of competition must surely be staged every year in the future.

There were many hard matches and several surprise results. For example, Ann Rothman and Giles Rowntree overcame Alan Skry and Jenny Turnpenny. Paul Rydning and Claudia Roe caused quite a surprise, too, by reaching the semi-final. The biggest shock was the defeat of the number two seeds, Alan Greenwood and Pat White, at the hands of Giles Jackson and Fiona Marsh. The latter pair reached the semi-finals where they eventually fell to the number three seeds Liz Thomas and Steve Willis. The top seeded Liz Ryman and Chris Willis reached the semi-finals without difficulty, but were then faced with Claudia Roe and Paul Rydning. The top seeds had to fight hard to win 21—18, 21—18.

The final was a dramatic affair between Liz Thomas and Steve Willis, and the favourites Liz Ryman and Chris Willis. In the first set the favourites set about proving their superiority and won 21—8. In the second set the former pair were equally determined and won almost as convincingly, 21—9. The final set was a nail-biting affair, with the latter pair leading 11—4 only to lose the lead at 12—12, and then Liz Thamas and Steve Willis proved the seedings wrong by winning the final set 21—15.

This is the first time either Liz or Steve have won a title at Guy's and full credit must go to Liz, who, although being relatively new to table-tennis competition matches, played most consistently throughout the tournament. Both won cups for their efforts. Liz Ryman and Chris Willis won medals.

This was a most enjoyable and entertaining evening, with no fewer than twenty-two participants. On 6th May this year we shall have our final tournament, the Handicap Tournament and the Men's Doubles, for which we hope to have a large number of participants.

Footnote.

Both Guy's I and Guy's II won their final matches, and it seems that Guy's I have won Division II and Guy's II have won Division III, although we still await official confirmation.

Chris Willis.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL

Applications are invited for the appointment of a **Trainee Registrar** in the Department of Diagnostic Radiology with duties to commence on 1st October, 1971. Appointment for one year in the first instance. Forms of application are obtainable from and should be returned to The Superintendent, Guy's Hospital, London, S.E.1, not later than **9th April, 1971.**

MILLER HOSPITAL

Applications are invited for the appointment of **Senior House Officer** in Medicine for the six months period 1st April to 30th September, 1971. Apply immediately to the Hospital Secretary, Miller Hospital, Greenwich High Road, London, S.E.10.

THE NEUROSURGICAL UNIT OF GUY'S, MAUDSLEY AND KING'S COLLEGE HOSPITALS

Applications are invited for the resident post of **Senior House Officer** for six months commencing immediately. The Unit, which is housed in the Maudsley Hospital, serves Guy's, Bethlem Royal Hospital and the Maudsley Hospital and King's College Hospital. Applications giving details of experience and the names of two referees, should be made by 10th April, 1971 to House Governor and Secretary, The Maudsley Hospital, Denmark Hill, London, S.E.5.

THE NEUROSURGICAL UNIT OF GUY'S, MAUDSLEY AND KING'S COLLEGE HOSPITALS

Applications are invited for the post of **Registrar** (Middle Grade) for one year commencing on 1st June, 1971. The Unit, which is housed in the Maudsley Hospital, serves Guy's, King's College and the Bethlem Royal Hospital and the Maudsley Hospital. Applications should be made by 3rd April, 1971 to the House Governor and Secretary, Maudsley Hospital, Denmark Hill, London, S.E.5.

GUY'S HOSPITAL DENTAL SCHOOL

Commencing on Wednesday, 21st April, 1971 a course in Conservative Dentistry primarily for F.D.S. candidates will be held at Guy's Hospital Dental School. The Course will consist of six sessions, from 6.00 p.m. to 8.00 p.m. on 21st, 23rd, 28th and 30th April, and 5th and 7th May, 1971. Fee: £10.50. Further particulars and forms of application which should be returned as soon as possible and not later than Tuesday, 13th April, 1971 may be obtained from the Dean, Guy's Hospital Dental School, London Bridge, S.E.1.

PERSONAL

FOREST HILL—11 minutes London Bridge. Open plan Town House. Large through lounge/dining room, three double bedrooms, bathroom, fitted kitchen. Two W.C's., utility room. Central heating, patio, garden. Separate garage. £9,500 freehold. Tel: 699 7982.

DENTAL SURGERY—near Guy's. Associate/Assistant required May to join Guy's man in well-equipped practice. Tel: 237 2085.

THE partners in a long established and expanding London West End private practice require an Assistant around the end of the year with a view to partnership. Postgraduate experience in high standard conservative dentistry essential. Box No. 3/3.

CHANGES OF ADDRESS

Brendan and Jacqueline Hicks, 9 Shornefield Close, Bickley, Kent. Tel: 01-467 0818.

Dr. and Mrs. K. Kelly, "Hollowdene", 31 Cronks Hill Road, Redhill, Surrey.

F. Summers, Esq., L.D.S., F.C.S., 56 Hickson Street, Merewether 2291, Newcastle, N.S.W. Australia.

Drs. David and Rowena Silk, "Hillside", Four Elms, Nr. Edenbridge, Kent. Tel: Four Elms 358

BIRTHS

BASHFORD—On 3rd January, 1971 at the Royal Cornwall Hospital (Treliske), Truro, to Andrew and Christine Bashford, a daughter, Justine Fiona.

CRAWSHAW—On 14th January, 1971, at the Royal Cornwall Hospital (Treliske), Truro, to Mary (née Yorke) and Andrew, a son, Paul Andrew, a brother for Ian.

MADDISON—On 24th January, 1971 to Sue (née Hunt) and John Maddison, a third son, Adam Charles.

We would like to remind our readers that all copy for inclusion in the "Gazette" must be received eight days before publication date.

Copy may be sent to us c/o The Front Lodge, Guy's Hospital or left in the "Gazette" pigeon-hole in the East Wing.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, please indicate whether or not this should be published.

Personal notices one shilling per word (pre-paid) (minimum £1. 1s. 0d.).

Non-subscribers will pay £1. 1s. 0d. (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

EDITORS N. D. S. BAX and A. M. TURNER
NEWS EDITORS R. M. DARLING and J. L. LEWIS
SPORTS CORRESPONDENT A. M. ROYSTON
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TEN PENCE VOLUME 85 NUMBER 2158

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

"Beauty is truth, truth beauty"

Women's magazines have always encouraged one to look as good as one feels, but never so emphatically and libido-levelled as today. The magazines advertise and encourage one to use innumerable preparations to remove cuticles, lift faces and prevent jaw lines sagging, nourish hair and increase desirability. There is even a tablet designed to purify the blood (sic) and thus rid the user of acne. One can only hope that its effects in pregnant mice have been fully studied.

A mysical aura is created around these preparations, added to by an unpronouncable name and high cost. Seemingly incongruously, as rapidly as people both inside and outside medicine say there is no mystique to medicine, other people and sometimes the same, are just as rapidly building a mystique around things such as cosmetics, slimming courses and health farms. People are very concerned that the few pence they pay as a prescription charge are well spent, but are quite prepared to spend hundreds of times this amount on slimming courses (approved as always by a doctor), health farms and things to keep all parts of the body fit for a television commercial.

There has been a recent flooding of the market with books and magazines containing "medicine for the people", explaining where the majority of old wives' tales went wrong. Although their contents are not on the whole directed towards basic first aid and in what sort of circumstances not to call the doctor but to the finer points of human relationships, they are at least a start. Sugar and cardiovascular disease can follow. With this deluge of information about medicine and their bodies one might have expected people to apply increasingly rigid criteria to their acceptance of beautifying and

slimming products. Even so, the faith some people place in the truly mystical qualities of some of these products remains unshakeable. It seems that diet-counsellors and aromatologists are often sought out in preference to doctors. Perhaps the latter are offering less of a therapeutic encounter. The fast-eroding mystique of medicine may leave diet clinics and health farms as the last outpost of quasi-medical mysticism.

One can only wonder what would happen if "therapeutic trials" came to beautifying agents and people took heed of the results?

The Student Voice

While students in almost every college are troubled by working out how they should be educated, students in Guy's generally suffer no such handicap. As was pointed out by Mr. Hewish in last week's *Gazette*, Guy's representatives at the London University Assembly of Councils did not even bother to attend.

We have a student's Education Committee but how seriously would they be taken if, for example, they proposed that the hospital reorganise itself so that many firms are abolished? We could learn much more of our practical medicine in the large hospitals where there are no students at the moment and there would therefore be many more patients for each student to become involved with. Or that a course in General Practice would be of more value than some of the specialist firms? Or that we should be based for the three years of clinical training on eighteen months in each of medicine and surgery with periods during which we attend out-patients and ward rounds on the specialist firms? The advantage of the latter system would be that enthusiasm, which so often wanes considerably on the specialist firms, would be maintained, since students would still be involved in their main interest. Or that a whole firm should be devoted to a course in clinical pathology and therapeutics, as important as anything else for undergraduate education? As it is, they suffer more than others from being delayed until they are, in bulk, committed only to short-term memory for the exam.

The argument against radical proposals is not solely or convincingly that they would not benefit our education, it is also that the amount of reorganisation would be frightening. It is for the students to decide if they accept that.

NEWS IN BRIEF

Professor Butterfield

Professor W. J. H. Butterfield has left Guy's to become Vice-Chancellor of Nottingham University. Educated at Oxford University and John Hopkins Medical School, U.S.A., he was appointed Professor of Experimental Medicine at Guy's in 1958, and Professor of Medicine and Additional Physician in 1963. His main interest has been diabetes, and he has been Chairman of the British Diabetic Association since 1967. He was awarded the O.B.E. in 1953. We wish him every success in his new post.

Mr. Blaikley

Mr. J. B. Blaikley, Consultant Obstetrician and Gynaecologist since 1941, has retired from Guy's. After qualifying at Guy's in 1928, he attained the F.R.C.S. in 1941, M.R.C.O.G. in 1933 and F.R.C.O.G. in 1944. He was Medical Superintendent of Guy's from 1958 to 1967. Among the many positions he held was the Presidency of the Section of Obstetrics and Gynaecology of the Royal Society of Medicine from 1964-1965. He was awarded the C.B.E. in 1967.

We wish him a long and happy retirement.

The Evelina Fire

As the national press reported in its usual inimitable and inaccurate manner, there was a fire at the Evelina Children's Hospital on Monday, 22nd March.

The fire was discovered by the Paediatric Registrar, and the Fire Brigade and the Guy's Fire Prevention Officer were both on the scene within two minutes of being called. The children were all evacuated within 10 minutes of the discovery of the fire, and were accommodated in offices on the ground floor. The porters tried to extinguish the fire but were unsuccessful because of the heat and smoke, but it was quickly brought under control by the fire brigade. The children were back in their wards within an hour of the discovery of the fire.

An operating list was in progress at the time, but it continued, as the fire was in a different part of the building.

The fire is thought to have started in the maids' quarters, whose interior was nearly gutted, and Rothschild Ward directly above was slightly damaged and is not yet back in use. No one was injured.

The staff of the hospital behaved outstandingly calmly and efficiently throughout.

At the time of the fire, Dr. Evans was taking his firm on a ward-round. While hearing the history of a patient, they noticed that nurses were calmly walking into the ward, picking up babies, and walking out again. No one noticed that anything was amiss until the firm saw that there were no babies left to look at and a member

of the nursing staff told Dr. Evans what was happening. They strolled downstairs to be met by a horde of firemen wearing gas masks and carrying hoses. One student went to the Casualty Department to inform them of the fire, but no one believed him until at that moment molten paint began to drip off the ceiling! The firm left the building to find an armada of police cars, fire engines and ambulances outside, and a few minutes later they heard the sound of a horse in a hurry, as a mounted policeman trotted round the corner, hothoof to the rescue. He proceeded to park his horse on the pavement and watch the activity.

Cosmopolitan Anatomists

Professor Warwick has recently returned from Hong Kong, where he was examining for 2nd M.B. The University of Hong Kong is connected with the University of London, and borrows examiners for some of its degrees.

Dr. Brookes is leaving at the end of the week for the West Indies, where he is to spend a term helping out at the University of the West Indies.

Subscription Leaflets

Due to the postal strike, the subscription leaflet was not inserted in the second issue of January but is enclosed with this issue.

Will you please read the 2 gns. as £2.10.

It would be appreciated if you could send us your subscription immediately as to post individual reminders would be very costly.

GUY'S DIARY

APRIL

19	M	1.00 Clinical Lecture. Dr. FLEMINGER.
22	Th	1.00 Clinical Lecture. Professor TROUNCE. "Drug Interaction."

THE ADDRESS AT THE MEMORIAL SERVICE

FOR

The Late Dr. W. H. H. Merivale

Walter Merivale was able to express anything he wished to say or write so beautifully that in trying to talk about him one has a feeling of inadequacy. This ability, combined with an acute sense of humour, enabled him to enliven many a dull meeting or entertain a host of friends with lively conversation. He used this talent extensively for the amusement of himself and others, and never ostentatiously, because he was essentially modest. Nor did he use it to gain the power over others which only a fluent tongue can give, but invariably kindly and sympathetically, for Walter was a very gentle man.

Despite the fact that his specialty tended to divorce him from contact with patients, he was a very competent doctor, although he would be the first to deny such ability. This clinical sense made him take his duties as Control of Infection Officer very seriously indeed, and any lack of responsibility by anyone caused him real distress. He spent a great deal of time visiting the wards, patiently enquiring about the incidence of infection and offering invaluable advice and help to anyone who asked for it.

Many a week-end's amusement must have been spoilt for him because he wanted to make sure that nothing was amiss with the ventilation in the Operating Theatres, and many a student must be grateful to him for his lucid and carefully prepared lectures and tutorials.

He was always up to date in his specialty and, as the scope of it increased in post-war years, soon realised that no single person could master the whole of clinical pathology. He therefore willingly handed over sections of this responsibility to others, and scrupulously ensured that his colleagues had fair and equal opportunities.

Likewise, he was always ready to learn, and when the Hospital's need for a Virologist became apparent, he cheerfully set out on the long road to train himself and gather the necessary team and facilities together. But above all, he ran a successful and happy department, and his sense of responsibility ensured that the welfare of his Junior Staff was always given constant attention.

Latterly, his principal recreation was sailing, and his experiences provided him with a fund of stories, mostly against himself, with which to entertain his friends.

Above all, he loved his family, and wherever he was or whatever he was doing, they were never far from his thoughts.

Guy's has lost far too many of its staff in recent months—none will be remembered with more affection than Walter Merivale.

P.J.H.

Cot Death

Neil Barber

Introduction

For many years the problem of cot or crib death (sudden unexpected death syndrome—SUDS) has taxed the minds of pathologists who in days past would commonly record the cause of death as "asphyxia due to suffocation". This, of course, caused much distress to the parents of a child who perished in such a way because added to their natural grief were the feelings of shame and guilt produced by the overtones of neglect and ill-usage implied by a diagnosis of this sort.

Pathologists, paediatricians and others gradually became uneasy about many of these cases since the facts often did not seem to be consistent with a death by suffocation. Much work has been done in an attempt to clarify the situation, but although progress has been made, the problem is not yet solved.

Definition

Cot death may be defined as the sudden death of any infant or young child considered to be in good health, or at most to be suffering from a mild illness with no expectation of a fatal outcome, in which a thorough postmortem examination fails to demonstrate an adequate cause for death.

Incidence

The incidence of cot death is one to three per 1,000 live births, depending on the criteria of different workers. These deaths account for 10—40 per cent of post-neonatal deaths in the first year, and about 10 per cent of all infant deaths.

Over the years the total infant mortality has fallen, whereas the number of cot deaths has remained fairly constant. Cot deaths therefore now constitute a greater proportion of total infant deaths.

The age incidence is fairly well established. The condition is rare over the age of one year, but the lower age limit is a little uncertain because at this end of the range prematurity and asphyxia may be included in the aetiology. A definite peak incidence between two to four months is shown in most studies.

It is commonly agreed that cot deaths occur predominantly in winter with most cases occurring in the coldest months, while a second peak appears around the month of May. The incidence is lowest in August.

Cot deaths more frequently involve boys than girls, and most workers have found 60—70 per cent of boys in their samples, although there are exceptions with some workers finding no sex difference and a few finding a predominance of girls.

Much attention has been paid to the weight of cot death infants at birth and death, but there seems to be no definite agreement on this at present. Some authors find a preponderance of overweight infants, while others find low weights. It has been pointed out by Geertinger (1968) that the accurate postmortem estimation of weight is difficult because of evaporation, dehydration and ante-mortem vomiting.

The incidence of cot death is higher in the lowest social classes and in the U.S.A. the incidence is higher in the non-white population. Mothers of these infants tend to be young.

It will be noticed that many of the factors so far discussed apply to all post-neonatal deaths, and care must be exercised in their interpretation.

Twin Studies

One might expect that study of cot deaths in twins would be interesting, and although there is as yet sparse information on this point, there are some fascinating accounts in the literature of simultaneous sudden unexpected death in twins (Cooke and Welch 1964; Geertinger 1968). The cot death rate seems to be slightly higher for twins than for all infants, but twins are almost always bottle fed and frequently have low birth weight. Many experts would argue that these factors alone could account for the slightly higher incidence in twins. Geertinger (1968) thought there might be an environmental factor in the simultaneous cot death of twins, but although he checked infants living under similar conditions of close contact, he found no case of simultaneous death (he had collected five pairs of simultaneous twin deaths). He thought that the quality of being a twin involved a predisposition to cot death. This would not necessarily be due to heredity, but some abnormality acquired during fetal life would tend to be shared by both members of a twin pair.

Respiratory System

Diseases of the respiratory tract are most often cited as the cause of death, and the seasonal distribution appears to be consistent with this. Sometimes respiratory symptoms have been noticed two weeks before death, although some workers consider these cases to be outside their definition of cot death.

The lungs are often found to be hyperaemic with small alternate areas of emphysema and atelectasis, and it is common to find numerous petechiae on the thymus, pericardium and pleurae in cot deaths. Petechiae *only* on the chest organs are very characteristic of cot death, whereas petechiae on the skin of the face are the characteristic lesions of mechanical suffocation.

The use of a soft pillow has been found by some to be related to the incidence of cot death and the presence of emphysema, atelectases and petechiae on the organs of the chest has been taken by many forensic medical authors as an indication of mechanical suffocation. Other workers do not agree. Death by asphyxiation may occur in infants, but one might expect this in feeble infants debilitated by pre-existing disease. It is worth noting that resuscitative measures

on a cot death infant may confuse the gross appearance of the respiratory system at autopsy. However, Camps (1970) considers that "they die a congestive, asphyxial type of death with no disease—in fact, suffocation". It must be made clear that this does not necessarily mean mechanical suffocation such as by a pillow, and indeed so many cot death infants are found lying on their backs with their faces uncovered that it would seem ridiculous to make such an assumption. Nevertheless, Simpson (1969) has suggested that some of these cases may be accounted for by the last convulsive movements before death turning the infant away from the mechanical cause of the obstruction. The initial obstruction causes congestion and the pouring out of saliva, mucus, oedema fluid and blood in the mouth. Even though the infant turns away from the obstruction, the accumulated fluid cannot be cleared quickly enough to avert death.

Aspiration of gastric contents into the lungs has been put forward as a cause of cot death, but for a long time forensic experts have considered that vomiting followed by aspiration is in itself a symptom of severe anoxia and not vice versa (Simpson 1947; Camps 1970).

In many cases of typical cot death, masses composed of desquamated bronchial epithelium with a few mononuclear cells can be squeezed out of the bronchioles. Many authors have considered this to be evidence of viral infection, but Parish *et al* (1960) have found a similar phenomenon in experiments with guinea pigs which suggests a different aetiology. Gunther *et al* (1960) found that most infants fed on cows' milk developed antibodies to the proteins in the milk. Parish *et al* (1960) found that dropping milk over the glottis into the larynx of milk-sensitised and anaesthetised guinea pigs led to their death with characteristic pathological findings of shedding of bronchial epithelium. It was hypothesised that cot death is due to an anaphylactic reaction following inhalation of cows' milk. There are many adherents to this hypothesis, and it certainly fits the known relationship between cot death and bottle feeding. However, as Geertinger (1968) says: "If a significant immune response to cows' milk occurs after a few meals in the first week of life, why then does hypersensitivity to cows' milk lead to SUD predominantly between the ages of three and four months? These infants have certainly been regurgitating now and then during the whole of that period".

There are other investigators who find the bronchial desquamation of no importance either in relation to viral infection or in relation to hypersensitivity to cows' milk. It is said that the desquamation of bronchial epithelium is a very early postmortem phenomenon, and it is possible that it is the special structure of the infant lung which is alone responsible for the observed desquamation shortly after death.

Another finding in the lungs has been that of a slight peribronchiolar infiltration with lymphocytes and plasma cells, and many workers have taken this as evidence of acute infection at an early stage. Granulocytes are nearly always absent, and it is presumed that a virus is involved in the infection. However, a similar infiltration has been found in infants who have suffered death by unnatural causes.

There are also conflicting reports of the importance of interstitial pneumonia, plasma cell pneumonia, pneumocystis carinii pneumonia and cytomegalic inclusion body disease, and as yet the relationship of these diseases to cot death is not clear.

Other Organs

Because a large body of opinion favours an acute viral infection as the cause of cot death, the spleen has been closely examined in order to detect the early stages of an infection, and indeed evidence of infection has been found on histological examination. Studies of the thymus have not shown the characteristic changes associated with infection, and unfortunately both bacteriological and virological studies in cot death have been mainly negative, and it is difficult to gather consistent evidence for an infectious basis to the syndrome. One can only hope that improvement in virological techniques will help to clarify the picture.

The adrenal glands have not received much scrutiny with respect to cot death, and significant pathological changes have not yet been demonstrated. Also, suggestions of cortisol insufficiency as a cause of cot death have not been substantiated.

Oedema of the brain is commonly found in cases of cot death, but the cause of this has not been established.

Rieders *et al* (1964) found a red substance in an alcoholic filtrate of brain tissue, and showed that there was a significant association between the presence of this substance and cot death. The red substance had not been purified and identified.

Geertinger (1968) in an impressive account put forward his theory that incomplete development of the parathyroid glands is the underlying cause of cot death. He thought that a disturbance of maternal calcium intake during pregnancy could produce parathyroid abnormalities in the infant and that the resultant disorder of calcium metabolism would cause a predisposition to sudden unexpected death. He argued that this would tally with the seasonal incidence of cot death, with winter pregnancy, summer birth and winter death. However, Ellis and Knight (1969) found no evidence to support his claim that there is a deficiency of parathyroid tissue in cases of typical cot death.

This recent theory is still therefore in the company of many others in the melting pot. We have advanced from the days when such concepts as "status thymicolymphaticus" were valid in a discussion of cot death, but much more work is needed before we reach the bottom of what is still a difficult problem, for it is almost certain that most cot deaths are due to natural causes.

Acknowledgments

I would like to thank Dr. R. C. MacKeith for providing the initial impetus for this article, and Professor Keith Simpson for allowing me the use of his library.

References

I have not given references for every statement since this would have resulted in a list about twice as long as this article, but the selected references given will provide an introduction to the literature.

CAMPS, F. E. (1970): The cot or crib death. *Brit. J. Hosp. Med.* *Vol.* 4, No. 6. 779.

CARPENTER, R. G. and SHADDICK, C. W. (1965): Role of infection suffocation and breast feeding in cot death. *Brit. J. Prev. Soc. Med.* **19**. 1.

COOKE, R. T. and WELCH, R. G. (1964): A study in cot death. *Brit. Med. J.* **2**. 1549.

ELLIS, H. A. and KNIGHT, B. (1969): Parathyroids and Cervical Thymus in Sudden Unexpected Death in Infancy. *Pediatrics.* **44**. 225.

GEERTINGER, P. (1968): Sudden Death in Infancy. Ed. Kugelmass, I. N. Charles C. Thomas (Publishers), Springfield, Illinois.

GUNTHER M., ASCHAFFENBURG, R., MATTHEWS, R. H., PARISH, W. E. and COOMBS, R. R. A. (1960). The level of antibodies to the proteins of cows' milk in the serum of normal infants. *Immunology.* **3**. 296.

PARISH, W. E., BARRETT, A. M., COOMBS, R. R. A., GUNTHER, M. and CAMPS, F. E. (1960). Hypersensitivity to milk and sudden death in infancy. *Lancet.* **2**. 1106.

RIEDERS, F., ETTER, R. and HERRON, G. (1964). A tissue constituent associated characteristically with unexplained infant deaths ("crib deaths"). *J. Forensic Sci.* **9**. 157.

SIMPSON, K. (1947): Pathology of sudden death. *Lancet.* **2**. 745.

SIMPSON, K. (1969). Forensic Medicine. 6th Ed. Edward Arnold (Publishers) Ltd. London.

VALDES-DAPENA, M. A. (1967). Sudden and unexpected death in infancy. A review of the world literature. 1954-1966. *Pediatrics.* **39**. 123.

GUY'S EAST MIDLANDS REUNION DINNER

The first Reunion Dinner for old Guy's men and their wives living in the East Midlands is to be held on 6th May, 1971, at Ye Olde Bell Hotel, Barnby Moor, near Retford, Notts. (reception, 7.30 for 8.0 p.m.; dress, dinner jacket and cocktail dress).

It is to be linked to a farewell to Professor Samuel Shone, who is leaving the Sheffield Regional Hospital Board to take up the Chair in Medical Administration at the new Nottingham University.

Invitations are being sent to all Guy's men living in the East Midlands, but those who have been missed out should write to Dr. C. S. Darke and Dr. J. F. Baker, 88, Kendal Road, Sheffield, S6 4QH.

mps

medical protection society est. 1892

Students!
Arrange membership now.
Full benefit immediately
you qualify.
Pay later at no extra cost.

Over 50,000 members enjoy

- unlimited advice
- unlimited legal aid
- unlimited indemnity

Full details from
Secretary:
Dr. H.A. Constable, Head Office
50 Hallam Street, London, W1N 6DE
Telephone: 01-580 9241
or
Regional Secretary:
Dr. P.G.T. Ford, Regional Office,
30 Park Square, Leeds 1
Telephone: 0532 42115-6

Medical Aspects of Adoption

Dorothy F. Egan

'The recent publication of a Working Paper on the proposals of a Departmental Committee set up under the chairmanship of Sir William Houghton in 1970 on the adoption of children, has led me to choose as my subject, the "Medical Aspects of Adoption". The Committee has invited comment not only from professional people and organisations on their recommendations, but have also put a number of open questions on which they seek advice before a final report is made to the government. This somewhat unusual step highlights perhaps the difficulties in drafting legislation which is sufficiently flexible yet at the same time precise enough to meet all contingencies in this human situation.

History

Adoption in itself is no new thing. An informal type of adoption has been practised in Great Britain for centuries, but it was not until World War I that enlightened people set up adoption societies to try to safeguard the future of the many war orphans and illegitimate children. At that time an adopted child was not legally a member of his adoptive family, nor was he able to obtain a birth certificate in his new name. Thus adoptive parents could never be sure that the natural parents might not turn up at any time to take the child away. It was not until 1926 that a procedure for legal adoption was introduced. From that time on, once an adoption order had been made by the courts, the rights of natural parents were extinguished forever, and the child was given a new birth certificate.

During the next two decades adoption societies were required to be registered; supervision of third party adoptions was introduced, and certain restrictions placed on the transfer of children abroad. By 1950, although adoption was primarily a social matter, it had by then a strong medical component. Considerable emphasis was placed on the health of the child and a medical certificate on the physical and mental health of the infant had to be included in documents placed before the courts. Many adoption societies and some local authorities in practice would not place a child who was not completely healthy in every way.

An attempt was made to change this attitude in 1954 when the recommendations of the Hurst Committee were published. This Committee proposed that an adoption order should not be refused on medical grounds alone, if the adopters were fully informed of the possible implications of the medical report and were willing to accept the child in spite of his handicap. No reference was made to this in the Adoption Act 1958 itself under which adoption is legally regulated at the present time; but in subsequent Regulations under the Act a form was published with headings for the medical examination of the child, which included a requirement for a Wassermann test and a test for phenylpyruvic acid, each to be carried out after the child had

reached the age of six weeks. In spite of the lead given by the Hurst Report, considerable weakness in this aspect of adoption medical practice persists. Some doctors still "play safe" in medical examinations and reject infants on very slender grounds, and thus prevent the adoption of children who might otherwise have achieved a happy, stable background. Prospective adopters themselves may become frustrated and angered by repeated disappointment or long-drawn-out procedures to the point that, in some instances, if and when adoption is ultimately achieved, they may be emotionally unable to accept the child.

On the other hand, the well-being of other children or the parents themselves in an adoptive family can be endangered if uninformed medical reports allow seriously handicapped children, including the mentally handicapped, to be placed with them for adoption. The adopted child himself may be rejected under these conditions. The doctors' task should be to explain to the prospective adopters any medical problems involved and to try to ensure that adoptive parents understand the child's medical needs and his future care and management, as well as the long-term implications on the family itself.

The Act did, however, bring in one new aspect of adoption medical procedure. For the first time a medical certificate of fitness of the adopters signed by a registered medical practitioner had to be provided to the courts with an application for an adoption order. Two important defects in this legislation are immediately obvious. In the first place the form of words, as prescribed in statutory rules:— "I examined ———— on ———— and have formed the opinion that he is physically, mentally and emotionally suitable to adopt a child" is useless and meaningless in its brevity. Secondly, although the guardian *ad litem*—a person appointed to speak before the courts on behalf of the child, usually the children's officer—has the duty to report to the court if there is any tuberculosis, epilepsy or mental illness in the applicant's family; the timing of his report is clearly wrong as the child by statute will have been in the care of the prospective adopters for a minimum of three months, and in practice often much longer. None of these conditions may necessarily be a bar to adoption of a child but they need expert assessment before the child is placed in the home.

The Present Position—Size of the Problem

2.6% of live-born babies (over 26,000 children) are adopted each year in Great Britain. This figure does not include those children rejected as unsuitable for adoption, or *de facto* adoptions which of course still occur.

In England and Wales almost two-thirds of adoption placements are made by agencies, i.e. voluntary adoption societies or local authorities. Third party adoptions form up to 5% of placements in different parts of the country. The remainder of legalised adoptions are direct placements with relatives, more than half of these by the mother herself. 80% of adopted children are illegitimate but only 30% of illegitimate children are adopted.

Important changes are now taking place. Although the number of would-be adopters far exceeds the number of children available for adoption (10 : 1, 1960) fewer healthy children are offered for adoption and there is a proportionate increase in the number of children with special problems needing placement—handicapped children, coloured children and children of mixed racial parentage. In 1966 only 1.7% of the total adoptions were of non-white children.

Recommendations of the Houghton Committee, 1970

This, then, is the background against which the Houghton Committee's recommendations, on which we are now asked to comment, have been made. Their proposals are based on the concept that the first and paramount consideration must be the long-term welfare of the child. This must take precedence even over the wishes and hopes of the adoptive parents, although both aspects are so closely interrelated that neither can really be considered separately. The Committee were very much influenced in their conclusions by the work of the Medical Group of the Standing Conference of Societies registered for Adoption.

Medical Examinations

Let us look at the medical examinations required. By whom and when should such examinations be done? What type of medical examination is required?

The Adopters

1. The Committee recommended that the general practitioner who knows the family and holds their medical records is the doctor who should be consulted. The examination should be done at an early stage when the home study is made by the social agency, i.e. before the baby is placed. The purpose is to ascertain their health and life expectancy, the stability of the marriage and the couple's emotional adjustment, particularly if it is relevant to their infertility from whatever cause.

The physical examination is clearly the insurance type of examination with which general practitioners are already familiar, but assessment of emotional and mental adjustment may be time-consuming and difficult, and in some instances, may require specialist advice. In any case, the family doctor's first interest is to his patients and he may be very well aware that rejection as adoptive parents may be a serious blow that can put them in a worse position than if they had not made an application. Under no circumstances should adoption of a child be used to mend a broken marriage or as a therapeutic measure for a neurotic woman, but these people have needs and the reasons for their rejection ought to be explained to them. The Committee's recommendation that agencies should try to have a paediatrician or a consultant physician or psychiatrist to advise them on the interpretation of medical reports and to act as medical referees will go some way to help the family doctor in his management of rejected applicants. It is hoped that consultation between the family doctor and the consultant adviser will become the usual practice in such cases. If there is a substantial delay after the examination of

the adoptive parents before the child is placed there must be a check-up at the time of the adoption application. A further comprehensive medical examination will be required if two years or more have elapsed. So, too, if a second child is to be adopted later, the same procedure would have to be followed.

A charming, good-looking boy, six years of age had been adopted as a baby of three months old by a childless couple who made an application to the courts for his adoption as soon as the probationary period of three months had expired. Unfortunately, he was a fretful baby, always possetting until he was 10 months old, and his adoptive mother, a cold, withdrawn woman, never fell in love with him. His adoptive father had a rigid outlook and he, too, did not take to his son, so that by the time the boy was three years of age they had both become completely demoralised by their failure as parents. They sought the advice of a consultant psychiatrist who placed the boy in the nursery section of a residential school for maladjusted children, where he spent the next three years of his life. When we saw him we found that he is a clumsy child with a mild neurodevelopmental disorder, but well within the normal range of intelligence. At school he is regarded as rather an endearing person, popular with his successive house mothers and the fourteen children who make up his group. By contrast, when he is at home for the holidays he soils and wets.

The point of this story is not that the boy's adoption unfortunately failed, but the fact that these people were subsequently allowed to take the boy's natural younger sister with a view to adoption! She has now been in their continuous care for three years and at first seemed to be fully accepted by them. It is perhaps fortunate that they themselves have hesitated to apply for an adoption order as they feared she "might turn out like her brother". There are currently signs that they are rejecting her also. Surely if legislation had required a comprehensive medical examination of these people before the second child was placed with them, the family doctor would have had sufficient evidence to urge their rejection as adoptive parents, or a consultant medical referee might well have taken this point of view?

The Working Paper does not discuss the question of the placement of a normal child in a home where there is already a severely handicapped child. The *B.P.A.* has suggested that this would be an unwise step which could be interpreted as compensating the parents for their bereavement of a normal child. In my view there is certainly very real doubt whether such a placement could be in the interest of the normal child.

2. The Child

(a) Parental Consent to Adoption

Under the present law a mother cannot give her consent to adoption until the child is at least six weeks of age, although he may be informally placed earlier than six weeks. There follows a probationary period of three months in the continuous care of the prospective adopters, who can at any time after they have received the child,

and after he is six weeks old, make an application to the courts for an adoption order. Therefore even under the most rapid conditions an adoption cannot be completed under $4\frac{1}{2}$ months of age and in practice the period is often much longer. Some 60 per cent of adoptions are completed by one year of age.

A minimum period of six weeks was introduced to give the mother time to recover from childbirth and to come to a decision whether the child should be adopted or not. There is some evidence to suggest that many mothers reach a decision within one week of the child's birth but probably more research is needed into this aspect of the problem. It is still open to the mother, however, to withdraw her consent at any time before an adoption order is made. This arrangement can create anxiety and tension for the prospective adopters—many of whom feel they cannot give themselves wholly to the child for fear of losing him after all. This cannot be in the interests of the child. It should be possible for consent to become final before an adoption order is made to safeguard the child from vacillations by the natural parents or even before a child is placed. The Committee proposes that the mother's consent will become final once it has been freely given before the courts—they have left the length of the minimum period open but have suggested that a period of four weeks might be given to the mother to allow her subsequently to change her mind, after which it will become irrevocable. Consent at the moment is given only for a specific placement and this, too, is to be changed to a general consent. If these proposals are to become law, there must be a speeding-up of consent hearings by the courts.

(b) The Medical Examination

The purpose of a medical examination of the child is not to pass or fail him, or to guarantee his future good health, but rather to get a clear picture of his present condition, and an assessment of his future development. As we know, there are considerable limitations in the field of prediction—but we recognise that certain pre- and peri-natal conditions carry a high risk of handicapping conditions, or a careful history may reveal genetic or other disorders in the child's natural family. Some disorders such as severe cerebral palsy or mental subnormality—which might be regarded as prohibitive—can be recognised early by skilled examiners.

The Committee recommend that the medical examination of the child should be done by a paediatrician or by a doctor (L.H.A. doctor or general practitioner) with training and experience in developmental paediatrics. Furthermore, that no child should be turned down for adoption on medical grounds without an opinion from a consultant paediatrician. The child himself will be subject to two medical examinations:—

(a) The timing of the first should be prior to his placement and the examining doctor should have available to him a medical history of both natural parents if possible, an obstetric and neo-natal report, details of the child's general development and a history of any illnesses he may have suffered.

(b) The second examination will be made at the time when an application for an adoption order is to be heard by the courts.

The child's developmental progress and general health in the adoptive home will be relevant. A neurodevelopmental disorder may become apparent during the period and may need to be explained to the adopters so that they fully understand its implications.

The importance of the Committee's recommendation to appoint a paediatrician or consultant physician to interpret medical reports and to act as medical referee is very evident in this connection. Dr. Christine Cooper reported in 1970, that in 25 per cent of voluntary adoption societies and in 53 per cent of local authorities acting as adoption agencies, the assessment of medical reports was made not by medical advisers but by social workers! We do not know how many children are rejected for medical reasons but paediatricians do come across children who have been quite unjustifiably rejected, either because the doctor who made the examination had not understood its purpose, or because adoption societies have misinterpreted medical reports.

Very recently I saw a warm and kindly couple who ten years ago took a baby of six weeks of age into their home from a voluntary adoption society and legally adopted her. The child, now well grown and not unattractive in appearance, is an uncontrolled epileptic having 12-16 grand mal seizures per month and is profoundly mentally subnormal. Her future care and management is an urgent problem and it is becoming apparent even to these accepting parents that residential care must be considered. Could this disaster have been prevented? Possibly not—the fits did not begin until the child was nearly three years old and yet, when one questions the parents, even at this distance of time there seem to have been some signs which might have alerted a skilled doctor. The parents recalled that the baby was certainly not smiling back when they received her at six weeks and she began to smile at $4\frac{1}{2}$ months when she was christened. There was a story, too, of restlessness and hyperactivity and disturbance of sleep pattern. Might these stories have been regarded as warning signs by a doctor skilled in developmental paediatrics if a second medical examination had been required at that date—or the significance of these signs been apparent to a paediatric referee if one had been available to interpret the report of the adoption agency?

Adoption by Foster Parents

Another type of adoption is adoption by foster parents.

If the child has been in the care of his foster parents for a period of less than five years an assessment of the situation will be made by the local authority, including medical examination of the prospective adopters and the child. If the recommendations of the Houghton Committee are implemented in these cases the local authority will be empowered to give or to withhold permission for an application for an adoption order to be made.

If foster parents have had the care of the child for more than five years it is proposed that they may make a direct application to

the courts to adopt but a report of a comprehensive medical examination of the adopters and the child must form part of the application.

While the Committee proposes to lay down the broad principles about medical requirements, details of practice will be left to professional guidance. The opinion of the medical profession is, for example, sought on the need for a routine serological test of the baby's blood for syphilis—at first sight it would seem to be unnecessary where it is known that the mother has been tested with negative results. I understand, however, that venereologists have advised that this procedure would not be safe.

Medical Records

Record forms for the medical examination of the adopters and of the child have been designed by the Medical Group. They are somewhat daunting in their length but are likely to become the basis of medical records which will in due course be presented under statutory rules.

There is little doubt in my mind that the task to design legislation that will ensure the future of *every* adopted child is probably impossible in our present state of knowledge. It is clear that when adoption does go wrong it goes very wrong, yet it is increasingly accepted that adoption probably offers the best chance to provide children in need with a normal home life and the opportunity to grow up with real loving, and lasting relationships. The proposals of the Houghton Committee on the medical aspects of this problem will go some way towards placing the emphasis increasingly on the welfare of the child.

EAST ANGLIAN DINNER

The Guy's Hospital East Anglian Dinner for 1971 will be held on Saturday, 8th May, 1971, at the Angel Hotel, Bury St. Edmunds, at 7.30 for 8.0 p.m.

The Guest of Honour will be Dr. G. W. Scott.

If any Guy's East Anglian has not received a notice of this dinner but would like to come, will he please write to:—Dr. C. Bishop, The Ipswich Hospital, Anglesea Road Wing, Ipswich IP1 3PY, Suffolk.

NURSING SECTION

To Use or Abuse?

It seems to be increasingly accepted in this country that when regarding property of any kind, a policy of "what's thine is mine" is the correct attitude to adopt. In any large institution this is commonly the case, and therefore hospitals are as much the victims as anywhere else.

Nurses are generally thought to be people who possess high scruples, but when their attitude to hospital property is observed, this is found to be totally untrue. Let us first look at the attitudes frequently displayed in nurses' residences.

For many reasons the nursing staffs of hospitals reside at their place of work. These Homes are nowadays made comfortable and provide many amenities. However, those who live in them often adopt an attitude of carelessness, and because the property does not actually belong to them, seem to think that they may abuse it without compunction. If these same people were living with their own families or in their own accommodation, their attitude would be different indeed. Why then do they behave in this way?

Secondly, let us look at the attitude of nurses towards property whilst they are working. As is to be expected there is within the wards a large amount of stock ranging from paper clips to crêpe bandages. These items are, of course, designed for the use, either directly or indirectly, of the patients, and in order to have an efficiently-run ward it is essential that they are available. However, unless one keeps everything very strictly under lock and key it is not feasible to prevent articles being removed. Since to do this latter would be virtually impossible, one has resignedly to accept it and order stocks accordingly.

The most disturbing aspect of all this is that nurses appear to consider it their birthright to misappropriate various items. If they were accused of stealing they would not only be surprised but grossly offended. They consider it not abnormal to remove a couple of crêpe bandages prior to going on holiday. Or alternatively to take home a bottle of milk to their flat each evening. In addition, the culprits are frequently not the most junior members of staff, but those who have held for many years highly responsible positions.

Nurses like to think that they belong to a profession. Can they, however, regard this as professional behaviour? It seems to be totally incongruous that persons who, throughout their working lives, have to behave continuously with complete honesty, should resort to what amounts to almost criminal actions at other times. Surely the strains and stresses of the work are not so great that abnormal patterns of behaviour should occur. As we are well aware, every family has its black sheep but it would appear that a whole flock exists in the nursing profession today. It is surely the responsibility of every member of the profession to ensure that such things are not occurring. If nurses are not to be trusted in this aspect, how can they possibly expect their patients to hold any respect for them, or even to trust them to undertake their care efficiently?

CORRESPONDENCE

Do you know we have a President?

SIR,—I should like to thank Messrs. Hewish and Jones for their letter published in the last edition of the *Gazette*. I agree wholeheartedly with their sentiment, particularly their excellent last paragraph, and only wish more students held the same views.

The returns for both the Students' Club and Presidential elections were appalling, as was the attendance at the A.G.M., particularly the absence of some of the new Council members. In so saying, I deplore my own absence, but I would like to explain to my electorate, at least the 15 of the possible 1,100 who showed enough interest to attend, that my absence during this period was planned several months before Presidency was even thought of.

I am not in possession of enough facts to pass judgment on Guy's apparent non-representation at the Student Representatives' Council meetings last year, but there does appear to have been a slip-up somewhere along the line. However, I must point out that the student representatives are students of medicine and dentistry and possibly more than other students, are not experienced in public speaking and student politics. They are subject to exactly the same pressures of work as everyone else, as well as being afflicted with a social conscience. I can say from personal experience that it is confusing enough to attend a formally conducted meeting and express one's own views, but when one is representing an establishment such as Guy's, the responsibility is tremendous. How can a student represent his fellows when they appear to have no views on, or even the slightest interest in, what is going on around them, although irreversible decisions taken now may intimately affect their future?

While the East Wing is open the majority will grumble along. They grumble about the food, but make no concrete suggestions for improvement. Most walk straight past posters, make darts or score-sheets from hand-outs, and then say they have not been told about meetings or elections—how many know we are now members of J.H.D.A.?

So far we have been lucky that the "lunatic fringe" has not become invasive, but would the majority even notice if it became highly malignant?

Yours sincerely,

LYNNE HAMPSON,
(Student President).

Guy's Hospital Students' Club,
Guy's Hospital,
London Bridge, S.E.1.

SPORT

BOAT CLUB

KINGSTON HEAD OF THE RIVER
6th March, 1971

Guy's sent two crews to the start of this race, but only the first boat came on to the starting line, as the second boat had an unfortunate encounter with an underwater obstruction, which holed the shell near the mid-line, causing them to sink. This was a second encounter with the water for the cox prior to the race, the first having occurred when, at the U.L. Head, he left the boat to free the rudder strings, but mistook the depth of the water into which he had stepped.

The 1st crew, rowing in the heavier restricted class of shell VIII, used the "flying start" to advantage, and settled in to a good firm stride which was maintained over the course, and despite the snow blizzard, the pressure was maintained well, to take us past two crews who provided little opposition. Before the final bend, the crew developed more life as they passed a number of supporters, including the Hospital's first ladies' IV.

This was not a refined row, but a very "beefy" performance, which won the restricted pennant by 44 seconds from the next crew in the class.

READING HEAD OF THE RIVER
13th March, 1971

The river at Reading is fairly narrow, and the space available for marshalling crews is small. Guy's crews were fortunate to row amongst the earlier starters, and therefore had only half-an-hour to wait in the biting wind. This was quite sufficient to cool everyone by several degrees and to anaesthetise the concentration.

The first crew, which rowed with one change from the previous week's winning combination, never appeared to open up completely to establish the high ratings which are necessary for so short a course. They did at times, however, demonstrate their potential by opening a two-length gap in fifteen strokes over the pursuing crew, Reading University I, despite the difference in class of boat (Guy's were again rowing in the heavier restricted boat). These efforts invariably softened too quickly, and at the finish, Reading was only held off by half-a-length. The finishing time was only 12 seconds slower than Downing College, Cambridge, who won the restricted pennant. It has since been learned via the "grapevine" that Downing were boating a crew which rowed above its status—rather like putting a heavyweight against a lightweight. A moral victory therefore.

The second crew must have been quite upset by the coach journey, as their performance did not match that of the following week. One must conclude from this, that the experience was valuable.

HEAD OF THE RIVER RACE
Mortlake to Putney

The Head of the River Race was founded by Steve Fairburn in 1926, when only 21 crews competed. This year, on Saturday, 20th March, 321 crews marshalled for the race, which amounts to 2,889 athletes, assuming that all the coxes train! This must, surely, be the largest single event in the world, and was run in the very smooth manner which crews have come to expect of the Tideway organisers. It is no mean feat to marshal so many boats in a fast current, so that they come on to the start at 10-second intervals, and then to time them to within 1/100 second over the reverse of the more famous Boat Race course—an ebb-tide from Mortlake to Putney.

The Guy's entry of three crews represented fairly accurately the attitudes of crews in general, to the event. The first crew, and its support squad, has trained hard for some time, and aimed for the highest position of which it

was capable. The second crew has trained, but as novices, have entered for competition experience rather than a high place. The third crew was the notorious Gentlemen's crew, renowned for their rest at Hammersmith Bridge, where a whisky bottle annually passes through the hands of each member of the crew; a gift from heaven some say; though others claim that "Mrs. Mansie's little boy" pinched it. This crew is purely a social one, as one might have guessed, and aims not just for a low position, but for the one prize we are ever likely to win in the face of national competition—The Wooden Spoon. Only once have they been thwarted—by a crew that sank, but which reboated to complete the course only two minutes behind the Gentlemen.

The 1st crew was modified to include oarsmen of experience for an attempt at a record placing, the Hospital's previous best having been five years ago when the crew came 65th overall. Three changes were made in the stern which displaced the previous bow four, and moved the stern four towards the bows. A fast Sims boat of continental design was borrowed, but the light build and rig made adaptation to the new conditions difficult, particularly as only three outings were possible before the race. Two of these were short and in the dark, when the escort of a police launch was appreciated.

On the day a good start was made at a rating of about 33—34. By Barnes Bridge contact was made with the crew that had started 10 seconds ahead. They were overtaken between Barnes and Chiswick Eyot. Between Chiswick Eyot and Hammersmith, three more crews were passed, having been cruelly teased on to the outside of the bend by the cox, and a further one at Fulham Football Ground. The pressure at which the crew rowed was hard, but the application was occasionally uneven due to a slight lack of co-ordination. However, the comparatively high rating of 35, set by our new stroke, compensated for some of these imperfections. With more practice, therefore, this crew could by more efficient application of the same amount of work, have improved their performance. The result was satisfying, but the crew did not achieve the record placing sought so keenly. It was galling, nevertheless, to realise that an improvement of only 15 seconds would have taken the crew well into the first fifty.

The 2nd crew, previously known as the "Wreckers" owing to various mishaps at previous Heads, seem to have benefited from the company of so many other crews, and finished the course with commendable style for their experience. They form the future of the club, and the bulk of the present club spirit. The 1st crew squad would have functioned with less purpose without their keenness and support at all times. Certainly, if the novices continue to improve and get as much time on the water as possible, Guy's may have reason to be proud of more crews in the near future.

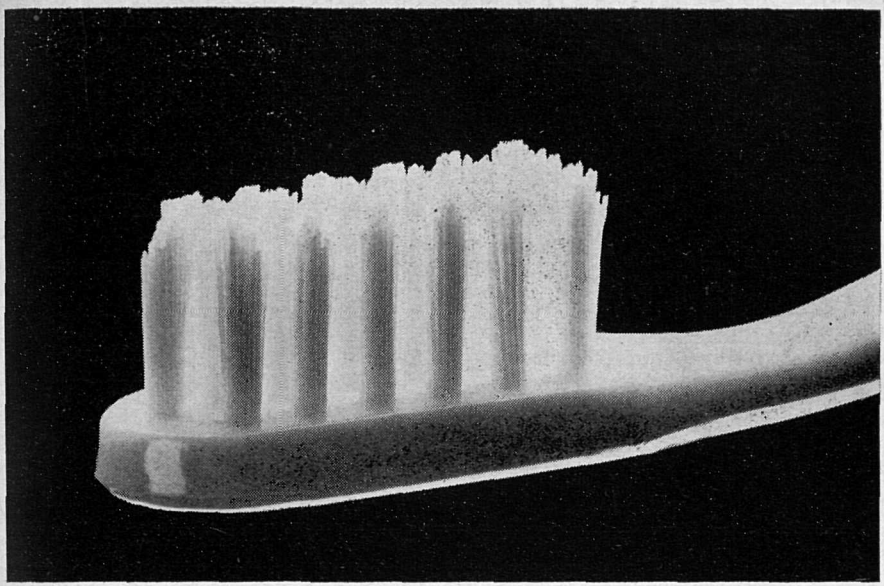
Results:

Crew	Kingston Position	Kingston Time m	Kingston Time s	Reading Position	Reading Time m	Reading Time s	Tideway Position	Tideway Time m	Tideway Time s
Guy's Hospital I	27	21	43	57	15	31	76	19	14.09
Guy's Hospital II				119	17	17	283	20	56.94
Guy's Hospital III							320	25	51.11

SUMMARY OF THE "HEAD" SEASON

The Guy's 1st VIII squad:—

1. *Won* the University of London Head of the River.
2. *Won* the restricted pennant at the Kingston Head of the River.
3. Were runners-up and moral victors of the restricted pennant at the Reading Head of the River.
4. Has not been overtaken by another crew during a race.
5. Has not been beaten by any College of the University at any time since the U.L. Head, thus keeping the title of fastest college crew.
6. Has been represented by—Tony Fenn, 4 in University of London I; Fred Moorhouse—cox in University of London II; Paul Stuart-Bennett—bow in Kingston I.



When they say this hurts, Sensodyne builds protection for sensitive teeth.

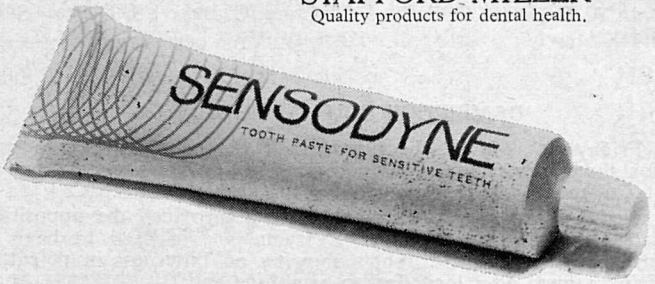
It's the old story, hypersensitivity means pain and fear of brushing, and this leads to oral neglect.

Sensodyne is a toothpaste especially produced for the adjunctive treatment of hypersensitivity. It contains strontium chloride – a therapeutic agent with a cumulative desensitising action.

The more your patient brushes with Sensodyne the less brushing hurts, so the habit of regular brushing is quickly regained.

Sensodyne helps 9 out of 10 sensitivity patients and completely relieves 2 out of 3.

STAFFORD MILLER
Quality products for dental health.



7. Has a reserve strength of 14 oarsmen, who have remained in training since January and will form the nuclei of the 1st and 2nd boats for the Inter-Hospital Bumps after Easter.

8. Would have preferred to weld one crew together for all the Heads.

9. Appreciated all the support received, particularly that of the President, Mr. J. W. Mansie, the University and adopted club boatman, Jim Wallys, and the Ladies' Boat Club who have taken the trouble to travel to each event.

10. Crews consisted—D. Barker, 23; A. Batch, 1, 2, 3, 4; A. Chivers, 1, 2, 4; D. Evans (cox) 1, 2, 3, 4; A. Fenn (U.L.I.); H. Fuller, 3; M. J. Gleeson (capt.), 1, 2, 3, 4; J. C. Miller, 4; G. Moulding (sec.), 1, 2, 3, 4; R. Newton, 2; C. J. L. Price, 1, 3; R. D. G. Pinkney, 1, 2, 3, 4; P. D. Robinson, 4; P. Stevenson-Moore, 1, 2, 3, 4; P. Stuart-Bennett, 1.

Where U.L. Head=1; Kingston=2; Reading=3; Tideway=4.

Coach, N. D. S. Bax.

2nd crews from—M. Browne, D. Carman, J. Squires, G. Robbins, L. Rabb, K. Freeman, S. Large, D. Curtis, G. Brown (cox), and spare members of 1st squad.

FOOTBALL

HOSPITALS CUP FINAL v. LONDON

Result—Lost 9—0.

Played at Cobham on Saturday, 13th March.

Once or twice in each season, every player has a day when he can do nothing right, when even the most rudimentary of skills seem to have been forgotten. For most of the Guy's team, such a day was last Saturday, and it was thus particularly unfortunate that the occasion should have been the final of the Hospitals' Cup. Guy's lined up against a muscular London side bearing minimal resemblance to their league side, indeed a neutral spectator casting his eye over one or two balding heads at the back of the London defence, might have been forgiven for doubting that he was in fact watching a Hospitals' Cup Final.

After quiet beginnings, the game suddenly turned London's way when Tim Walker irrevocably failed to hold a simple shot. Somewhat unnerved by this unhappy start, the defence began to show signs of uneasiness, and Guy's were soon two down when McConnell was caught out of position. A rare spell of Guy's dominance then showed, and Drage, McClure and Winter all came close to scoring. However, a series of elementary mistakes were snapped up by the London forwards, and by the interval, Guy's were five down and as good as beaten.

To their credit, Guy's didn't stop running in the second half, and Baker was as courageous as ever up front, but further individual errors presented the London with four more goals. This was indeed an unhappy afternoon for the team and particularly for the captain, John Edwards, who throughout the season has led the side with great enthusiasm and unfailing humour. With a relatively young side, Guy's have done well to progress so far in the competition, and to him must go much of the credit for this achievement.

Team: T. Walker, D. McConnell, N. Harradine, M. Drew, M. Winter, J. Edwards, A. Godman, P. Colly, I. McClure, C. Baker, S. Drage. Substitute, H. Holliday.

SQUASH

CAMBRIDGE SQUASH TEAM, 1971

On Friday, 5th March, the first squash team set off in two cars from Guy's for the annual tour of Cambridge, for matches against two of the strongest Colleges and the Cambridge town and county S.R.C.

On a cold Friday night, St. John's College provided the opposition, and Guy's had a decisive 5—0 victory. Everyone was pleased to have such a successful start, and with St. John's showing no bitterness in defeat, we all went off for a meal at a local Indian establishment.

AFTER GRADUATION... WHAT?

The newly qualified Dental Surgeon leaves hospital with a fund of professional knowledge but generally ill prepared for putting this to the practice of earning a living.

The first assistantship is of paramount importance, with special emphasis on working with a Principal who can provide the right professional guidance and bearing in mind such essential matters as surgery conditions, remuneration, location and partnership possibilities.

LOCUMS LTD. specialize in launching young graduates into professional practice. Assistance to thousands of Dental Surgeons has been our business for many years. So consult Our Registrar today for free, friendly and helpful guidance. Ring—Write or Call:

LOCUMS LTD.

30 THURLOE STREET, SOUTH KENSINGTON, LONDON, S.W.7. Tel. 589 7292 (5 lines)

The following evening, Guy's played Selwyn College, and just lost a very close and exciting match 3—2. John Mackay and Chris Mackenzie won with little difficulty against fairly mediocre opponents, but Jerry Owen, Edward Evans and John Lewis were all beaten three games to two, by members of the "Gaudus" squash team, after losing commanding leads. Owen, in particular, played very well, leading Malcolm Bruce-Lockhart (brother of the British International) 2—0, before his confidence deserted him. Selwyn, their generosity possibly stirred by this victory, treated us to an excellent meal, and it was well into Sunday morning before we returned, rather exhausted, to our hotel.

The final match of the tour was played on the Sunday afternoon against Cambridge City S.R.C. The effects of the late nights and two Indian meals, were, by now, beginning to be felt and, apart from Edward Evans, who, by playing some very fine attacking squash, beat Professor Calne (ex-Guy's) 3—2. The rest of the team could not find their touch, and Guy's went down by 4 matches to 1.

An extremely enjoyable week-end was had by all, and it is hoped that more of these tours can be arranged in the future. Quite apart from the squash, the peaceful atmosphere of Cambridge provided a very welcome respite from the hurly-burly of Borough life.

Team: Jerry Owen, Edward Evans, John Lewis, Chris Mackenzie, John MacKay.

C.M.

HOCKEY

JUNIOR HOCKEY CUP FINAL

v. St. Thomas, at Cobham.

Result—Lost 0—4.

This score, and the way in which it was achieved, reveals most of the limitations in the present Guy's second side.

With the weather and pitch near perfect, Guy's were up against an experienced Thomas' side. During the first half, the sides appeared to be evenly matched, although several half-chances were thrown away by the Guy's forwards after some especially good moves down the left-hand side of the pitch. John Shutes unfortunately had an early collision which resulted in a reduction of his usual excellent effectiveness as an organiser of forward moves. Guy's were unlucky to be one down at the half-time whistle, due to an extremely unfortunate defensive error.

The second half saw the rot set in. A positional change of right wing and centre-forward had to be reversed within ten minutes due to some rather vicious tackling from the opposition. This type of tackling further manifested itself by another hack on Brian Martindale's shin, bringing the number of forwards with decreased mobility up to three.

Apart from the continual muttered "slanging match" from one of the backs to any member of his own team who happened to be near him, the defence, faced with an onslaught of good opportunist forward play by St. Thomas' did well. Three further goals came within a short space of time, but Guy's did manage to find some open spaces to force the opposition back into their own territory for the latter part of this half.

Guy's lost to the team that deserved to win. They kept their heads while we lost ours. The lack of real scoring power by any of the forwards was all too obvious. In defence there were two goals we should not have let in, and two goals that few goalkeepers would have stopped.

In midfield, lack of intelligent passing and real co-ordination for a great proportion of the time were presented to a side that utilised and capitalised on our weaknesses. It just seemed a pity that while Duckworth and Sparrow ran themselves into the ground, other members of the team couldn't shake themselves into really concentrating on the game.

In this team we had, potentially, a very good side. I hope next year's Cup side will learn from this report.

Team: John Cottingham, George Chasak, Nick Matthews, Bill Brownlee, Paul Duckworth, Charles Crawshaw, Ian Cooper, Geoff Sparrow, Brian Martindale (captain), Barry Jones, John Shutes.

I.R.C.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL

Applications are invited for the post of **Research Registrar/Senior Registrar,** to work on the investigation and treatment of allergic and other immunological disorders, duties to commence as soon as possible. Application forms are obtainable from and should be returned to the Superintendent, Guy's Hospital, London, S.E.1, from whom further details are obtainable, not later than **23rd April, 1971.**

GUY'S HOSPITAL

Applications are invited for the appointment of a **Locum Senior House Officer** in Clinical Pathology, with duties to commence on 1st May, or as soon as possible thereafter, until 30th September, 1971. Forms of application are obtainable from and should be returned to the Superintendent, Guy's Hospital, London, S.E.1, not later than **21st April, 1971.**

GUY'S HOSPITAL
HOUSE APPOINTMENTS
1st June, 1971

Applications are invited for the following house appointments due to begin on 1st June, 1971. Forms of application are obtainable from and should be returned to Mrs. Webster, Administrative Assistant for Medical Staffing, not later than **23rd April, 1971.**

The following house appointments will be for six months and normally will be open only to pre-registration candidates applying for their first appointment and not to candidates seeking their second six months' appointment:—

House Physicians 4
House Surgeons 3
Throat and Ear House Surgeon 1
Orthopaedic House Surgeons 2
(The successful applicant will be required to spend six weeks at New Cross Hospital.)

Gynaecological House Surgeon 1

The following house appointments will be for six months and will be open to candidates who have already completed their first six months' appointment at Guy's or elsewhere:—

House Physician 1
House Surgeon 1
Children's House Physician 1
Genito-Urinary House Surgeon (or post-registration) 1
House Surgeon to the Thoracic Unit .. 1

The following post-registration and S.H.O. appointments will be for six months:—

Resident Obstetrician (post-registration) 1
Casualty Officers (S.H.O.) 2
Resident Anaesthetists (S.H.O.) 2
Senior House Officer to Nuffield House (S.H.O.). 1
Senior House Officer to the Renal and Transplant Units (S.H.O.) 1

EVELINA HOSPITAL

Children's House Physicians (post-registration 2
1 to commence 1st June, 1971.
1 to commence 1st August, 1971.
Casualty Officer (S.H.O.)
(part-time, six mornings a week) .. 1

ST. OLAVE'S HOSPITAL

House Physician (pre-registration) 1
(preference given to second 6 months candidate)
House Surgeon (pre-registration) 1
(preference given to second 6 months candidate)
Senior House Surgeon (S.H.O.) 1

NEW CROSS HOSPITAL

House Physician in General Medicine and Geriatrics (pre-registration) 1
(*preference given to second 6 months* candidate)

OUTER HOSPITALS

Preference will be given to second 6 months candidates for the following posts, but first 6 months candidates may apply.

HITHER GREEN HOSPITAL

House Physician in General Medicine and **Infectious Diseases** 1
(Locum available 15th-31st May.)

GREENWICH DISTRICT HOSPITAL
(married accommodation available)

House Surgeon with E.N.T. to Mr. O'Flynn, Mr. Wilson, Mr. Hollis and Mrs. Wengraf (pre-registration) 1
House Physician to Dr. Mallinson (pre-registration) 1

LEWISHAM HOSPITAL

House Physician to Dr. Price (pre-registration) 1
House Physician to Dr. Roberts (pre-registration) 1
(Locum available 15th-31st May.)
House Surgeon to Mr. Ivo Smith (pre- registration) 1
(From 26th May)
House Surgeon to Mr. Lynn Evans (pre-registration) 1
(Locum available from 17th-31st May)
House Surgeon with Orthopaedics to Mr. Monty, Mr. France and Mr. Bingold .. 1

MILLER GENERAL HOSPITAL

House Physician to Dr. Hartley, Dr. Bassadone and Dr. Mallinson (pre-registration) 1
House Surgeon to Mr. Candy, and Mr. Eldin (pre-registration) 1
House Surgeon to Mr. O'Flynn (pre-registration) 1

ORPINGTON HOSPITAL

House Surgeon *with Orthopaedics* to Mr. Boxall and Mr. Lam 1
House Surgeon with Orthopaedics to Mr. Walker Brash and Mr. Lam (pre-registration) 1
House Surgeon with Gynaecology to Mr. Boxall and Miss Austin (pre-registration) 1
House Surgeon with E.N.T. Surgery to Mr. Walker Brash and Mr. Rainer (pre-registration) 1
House Surgeon with Dental to Mr. Boxall and Mr. Macdonald (pre-registration) .. 1

PEMBURY HOSPITAL

House Surgeon (pre-registration) 1
House Physician (pre-registration) 1

ST. NICHOLAS' HOSPITAL, PLUMSTEAD

House Physician to Dr. Scott (pre-registration) 1

ST. HELEN'S HOSPITAL, HASTINGS
House Physician in General Medicine and Geriatrics to Dr. R. Irvine (pre-registration) 1

P. J. HELLIWELL,
Superintendent.

March, 1971.

GUY'S HOSPITAL

The Board of Governors of Guy's Hospital invite applications from registered dental practitioners for the following appointments to commence on 1st October, 1971.

Department of Conservative Dental Surgery

Registrars/Demonstrators to attend preferably on 6 or 5 sessions a week.

Department of Dental Prosthetics

Registrars/Demonstrators to attend on 6, 5, 3 or 2 sessions a week.

Dental Department for Children and Department of Orthodontics

Senior Registrar, full-time.
Registrar, full-time.

Clinical Dental Surgery

Senior Registrar, full-time.

Department of Periodontology and Preventive Dentistry

Registrars/Demonstrators to attend on 5, 3 or 2 sessions a week.

Casualty Department and Oral Surgery

Registrar/Demonstrators to attend full-time and 6 or 3 sessions a week.

Dental Radiology

Registrars/Demonstrators to attend on 6, 5 or 3 sessions a week.

The posts will be subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff in the National Health Service. Forms of application are obtainable from and should be returned to the Superintendent, Guy's Hospital, London, S.E.1, not later than **23rd April, 1971.**

The undermentioned prizes have been awarded during the 1970-71 session to date:—

1st Clinical Prize:
P. J. Calvert—Prize.
R. G. Dent—Certificate.

Charles Forster Prize in Cardiology, February 1971:
R. J. Wainwright—Prize.
Mrs. F. E. Jones—Certificate.

Michael Harris Prize in Anatomy, February 1971:
Miss D. P. Carter—Prize.
Miss A. Z. S. Rohatiner, R. C. Saumarez, J. Wynne-Jones } Certificate

Wooldridge Prize in Physiology, February 1971:
R. C. Saumarez, M. J. Wink } Bracketed equal, Prize shared

Gowland-Hopkins Prize in Biochemistry, February 1971:
A. P. Wozniak—Prize.

Examination for the Prize in Pharmacology, March 1971:
I. E. Hanner, R. F. Massey } Bracketed equal, Prize shared.
P. G. Davies—Certificate.

Jean Morton Prize, 1970-71:
Mrs. F. E. Jones.

Beaney Prize in Pathology, March 1971:
P. J. Marriott—Prize.

PASS LIST

STATE FINAL EXAMINATION, *FEBRUARY, 1971*

The following Nurses have passed the Final State Examination held in February, 1971:—

Allen, P. M.
Astbury, S. P. (née Whall)
Barnett, F.
Bell, S. M.
Boaz, A. C.
Boorman, P. A.
Bundle, C. M.
Butterworth, J. C.
Callaway, A. L.
Coates, S.
Dunn, K. M.
Elms, S. M.
Finch, C. A.
Fleming, J. T.
Graham, M. P.
Griffiths, A. J. S.
Haywood-Trimming, D. J.
Hillson, M.
Hoskins, S. M. F.
Hustwitt, N. D.
James, Cheryl Anne
James, Evangeline Victoria Yvonne
Jones, A. G.
Kemp, M. F. (née Willbond)
Maclean, E. S. D.
Mason, L. J.
Morgan, E. A.
Nettleship, C. M.
Pilliner, M. F.
Rastall, H. V. M.
Rice, F. S.
Rogers, M.
Simpson, R. E.
Sinclair, K. J.
Smith, Anne Margaret
Smith, Gillian Susan
Spibey, P. C. J.
Stockwell, J. A.
Stone, D. E. (née Johnston)
Tomlin, S. M.
Trubody, A. J.
Walter, P. A.
Wood, J. H. (née Burfoot)
Langford, J. M. (née Kirby)
Tetley, C. R.
Tomlinson, S.
Turner P. A.
Vincent, J. A (née Rouse)
Woodland, P. D.
Yarrow, C. M. (née Huntingdon)

PERSONAL

Dental Surgery, near Guy's. Associate/Assistant required May, to join Guy's man in well-equipped practice. Ring: 237/2085.

CHANGES OF ADDRESS

Mr. and Mrs. Frank Cook, 21 Hamilton Court, Chilston Road, Tunbridge Wells (from 25th March, 1971). Telephone. 22038 (Remains unchanged).

P. E. Gerrard, B.D.S., L.D.S., General Hospital, Miri, Sarawak, Federation of Malaysia.

Mr. and Mrs. E. Stuart Smith, 'Winyards,' Silver Street, Misterton, Nr. Crewkerne, Somerset.

BIRTH

PARKHOLM—To Barbara and John, on *18th* March, 1971, a little girl (Clare Louise), to join Clive.

GUY'S HOSPITAL GAZETTE

EDITORS N. D. S. BAX and A. M. TURNER
NEWS EDITORS R. M. DARLING and J. L. LEWIS
SPORTS CORRESPONDENT A. M. ROYSTON
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TEN PENCE VOLUME 85 NUMBER 2159

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Cense ourselves

The tolerant would call it a demonstration of democracy in action. The practical would call it the cavortings of the lunatic fringe, who are fortunately a minority. One has also to be thankful that they were not involved in compiling the present national census or our Welfare State would then be run even more irrationally than at present. It is in no way amazing that the very people who now criticise the census would be among the first to criticise it for entirely different reasons when they find it failed to establish the needs of the community in the future. In its broadest sense this is what a census should do and is what the present one will do.

Although people become sensitive when an official government form asks for their name, address and number of children, this information is given freely at a medical interview. If it were not, doctors would be impeded in their jobs and medical students in getting a reasonable sign up. Maybe it is the element of instant fear a patient experiences when something goes wrong that encourages him to offer any information, however embarrassing, that he feels may help in his recovery. When the same person is asked for information that may help more people than him alone, he becomes reticent. One can but hope that the voluble excesses of the few will not persuade people to obstruct the census.

Medicine has its "censuses", the majority being concerned *per se* with health, for example, mass X-ray and cervical cancer schemes. Rarely it seems is the management side of medical care analysed in such detail. Time and motion studies and demand and resources studies are still phrases that have only been heard of in some quarters. The ratio of wasted to used, and used well, equipment, food, drugs, doctor-

hours, student hours and so on interminably is too high.

Our awareness of the theory and practice of efficacy and efficiency in some spheres of medicine is appallingly small and in these it is time we learnt to spell the word statistics.

True Blue Genes

It is often said now that family doctors have had foisted upon them the rôle of priest and counsellor for much of the community. Since the middle of the nineteenth century, when science established its claim to an independent judgment on all things visible, often relying upon invisible entities to rationalise itself, the conspicuous success of the physical sciences applied to medicine has carried with it the faith that such knowledge embraces and cures all.

An anomalous situation it surely is, for doctors are no better qualified than a patient's close friends to deal with problems of the home, and frequently find they have a great deal less time than the next man, particularly if the next man is not a doctor. Naturally he learns through experience how best to help people, if only by acting the uninvolved but friendly listener.

So, he has little special knowledge, little magic to help with a drunken violent husband but that is not the only disadvantage of the doctor's present position. He now has the power to decide which women may have a termination of pregnancy, and is expected to advise patients not to have children when there is a possibility of genetic abnormality. But are we clear what constitutes such a condition, or who we are thinking of when we warn against child-bearing? Presumably it is not in the interests of the over-crowded community to bring children into the world with a strong family history of cancer, or diabetes, or gross stupidity. Many of us would not have passed the test, but in the interests of prophylactic medicine we shall be expected to decide whose genes to encourage. Have we the competence?

GUY'S DIARY

APRIL

26	M	1.00	Clinical Lecture. Mr. FAWCUS. "Communication Disorders in Adults."
27	Tu	1.00	Clinical Lecture. Dr. GRAHAME. "Hypermobility Syndromes."
30	F	1.00	Clinical Lecture. Dr. SOWTON. "Diagnosis and Treatment of Heart Block."
		2.15	Combined Round. Dr. HOUSTON and his firm present some cases.

MAY

3	M	1.00	Clinical Lecture. Dr. HYAMS. "Differences between Geriatric Medicine and General Medicine."
4	Tu	1.00	Clinical Lecture. Dr. WAYTE. Pre- or Post-operative Radiotherapy.
6	Th	1.00	Clinical Lecture. Dr. W. H. SHELDON, of the John's Hopkins Hospital. "Some Serum Protein Constituents of Inflammatory Exudates."
7	F	1.00	Clinical Lecture. Mr. SCHURR. "Chronic Pain."
		2.15	Combined Round. Dr. MALLINSON presents some cases.

NEWS IN BRIEF

Student Grant Review

The triennial review of student grants by the Department of Education and Science is at present about to enter the third and final phase of negotiations, evidence having been submitted by the student bodies (B.M.S.A., B.D.S.A., B.U.S.A., B.P.S.A. and N.U.S.) and the Local Education Authorities.

The B.M.S.A. and B.D.S.A. felt that the most needy topic on which most headway was likely to be made was clinical grants. However, to date the Department has refused to recognise that clinical students are in a different position from their non-clinical fellows.

We hope that our final submission will clarify the situation. Very briefly, our argument is as follows:—

Over a 30-week period a non-clinical student receives £14 per week. From this he must pay board and lodging, the National average for which (according to the Brown report on Student Grants of 1968), is £7.38; in London being £7.99. This leaves £6, of which £1.75 is pocket money, the remaining £4.25 being for lunches, books, clothing, laundry, etc. However, the clinical student receives £11 per week for working a 48-week year. Deducting board and lodging and pocket money, this leaves £1.25, which is a totally inadequate figure.

The clinical student is in a particularly difficult position as, working 48 weeks per year, he cannot supplement his grant with vacation earnings, as can other students. Every student needs a period free from study and work, and except for £1.75 per week pocket money a clinical student must pay for his holiday from his year's grant, and thus needs a holiday allowance.

Over a 30-week period the Department makes a distinction between London and provincial students, but for the extra 18 weeks *everyone* gets £7 per week. Does the cost of living in London decrease for 18 weeks of the year?

A high standard of dress is required of clinical students to maintain the confidence and co-operation of patients on whom their education depends, and it is felt that this requires an extra allowance.

The N.U.S. are pressing for abolition of the means test, but as this is likely to take some time to be implemented, the B.M.S.A. is making a special plea for clinical students, which is backed by N.U.S. Having been dependent on their parents for 2—4 years, clinical students then begin a 48-week year, during which they are physically independent, but financially wholly dependent on their parents. It is a great burden for parents to support one child for 5—7 years, but when there are other sibs, it is not surprising that they are becoming more reluctant to make the parental contribution, the situation being aggravated by the fact that holiday work is imposible.

Publicity was directed at people who can influence the Department and included letters to L.E.A's., M.P's., mass lobbying, press coverage, etc.

For the final assault before Stage III letters will be circulated to

all students to sign, or better still copy out, and send to their M.P's., within the same week as the meeting (probably 5th May), so that the D.E.S. is bombarded from all sides.

The Handcock Prize

We would like to congratulate Alison Hill and Sarah Lange on winning jointly the Handcock Prize of the Royal College of Surgeons, awarded as a result of their performance in the Conjoint Surgery examination.

Mrs. Amanda Maloney

Guy's Hospital Students' Club extend their sincere sympathies to Mr. Sidney Maloney, one of the East Wing porters. His wife, Mrs. Amanda Maria Maloney, passed away on 24th March, 1971, after a long illness.

The Guinness Stroll, 1971

Guinness is holding its annual march of masochism on 8th May, 1971, from Compton to Godstone. Tea, sandwiches, Guinness and other refreshments will be provided free and all successful strollers will be treated to a new tie and lunch at the Guinness brewery. The most successful hospital will win the Guinness Trophy and the hospital with the most successful ladies will win the Medical Sickness Society Trophy.

Entry forms will be available in the Colonnade on 26th, 28th, 30th April and 3rd and 4th May, from 1.0 p.m. to 2.0 p.m. Closing date is 4th May, and the entry fee, which covers the coach ride to and from the stroll, is 30p.

This year it is hoped that some strollers will be able to find sponsors for a charity of their choice. If anyone is interested, please contact Stuart Weedon or David Cottam, either in the East Wing or in the Colonnade at the above dates.

The Prevention of Parental Anxiety

R. W. SMITHELLS

"ANXIOUS. Troubled in mind about some uncertain event; being in disturbed suspense."—*Shorter O.E.D.*

"ANXIETY is the interest paid on trouble before it is due."—*Wayside Pulpit.*

It is important at the outset to distinguish between anxiety and concern. The human young is more completely dependent upon others for his survival than the young of almost any other species, and is certainly dependent for a longer period. If his cries for food and warmth are ignored, he perishes. The parental response to these cries, not only in infancy but beyond, is a deeply ingrained instinct and is necessary to the survival of the species. The unconcerned parent—the neglectful parent—is an abnormal product of society and presents problems of her own. Concern is a normal, healthy and necessary state of mind.

Anxiety is altogether different from concern. It is worry, it is being "troubled in mind", it is being "disturbed". Anxiety is tense; concern is relaxed. Anxiety is a destructive emotion; concern is constructive.

It is worth noting in passing that "anxiety" and "anger" both come from the same Latin word, *angere*. The Romans and their predecessors were certainly observant, for anxiety is probably the most potent cause of anger. Every doctor learns, sooner or later, that the angry patient or parent is not necessarily a stupid, obstructive, unappreciative creature. Far more often he is a bewildered person seeking information and reassurance.

Before discussing the prevention of anxiety of the soul-destroying kind, it is as well to recognise that there is a superficially similar but fundamentally different phenomenon, recreational worrying. I may be mistaken, but I think some people enjoy worrying in the same way that others enjoy ten-pin bowling. The recreational worrier usually has an exceptionally stable background—she has "nothing to worry about", but is not really happy except when worrying. If misguided reassurance is laid on too generously, an alternative worry will appear within days. If a recreational worrier stops worrying for more than a few days, she is probably ill. Worrying is a good word for this. It conjures up a picture of a terrier with a stuffed toy, locked in mortal combat but with tail furiously wagging.

Anxiety is sterner stuff. It spoils sleep, appetite and peace of mind.

Professor R. W. Smithells is Professor of Paediatrics, University of Leeds and Consultant Paediatrician, United Leeds Hospitals and Leeds Regional Hospital Board.

Its principal ingredient is uncertainty. Sometimes it is generated within the immediate family, sometimes by relatives or over the garden fence, and sometimes (let's face it) by the doctors. Before discussing some examples, it is important to recognise the specific element in most anxiety. I am indebted to Dr. Ronald MacKeith, of Guy's Hospital, for teaching me about specific anxiety. It is highly relevant to the process of reassurance. It means essentially that if I am anxious it is not in a vague, diffuse kind of way. It means that I am anxious about something in particular, and I shall not be reassured until my mind has been set at rest about that particular something. My particular worry probably stems from one of three sources :

(a) Common medical knowledge (pain in the chest means heart disease: coughing up blood means T.B.).

(b) Something I read or saw on T.V. (the weekend supplements, women's journals, etc.).

(c) Something in the family (the best reason for taking a careful family history is to reveal secret fears).

One final basic principle : parental anxiety may result from child illness, but it can also cause it and can certainly perpetuate it. A vicious circle can therefore be established in which the parents' anxiety perpetuates that which is making them anxious.

> Michael and his twin brother, aged four were playing on the playground slide. They climbed the ladder, but following a dispute over priorities Michael descended by the direct route and banged his head on the concrete. Damage appeared slight, but he subsequently complained of headache and was irritable. He was referred to hospital when these symptoms persisted. Careful clinical examination and X-ray of skull revealed no abnormality. Mother was reassured.
>
> A month later his symptoms persisted. Examination was again negative. Mother was reassured again and a sedative was prescribed for Michael.
>
> A month later there was still no change. At this visit mother volunteered what the wise doctor might have elicited sooner. Father was epileptic, and epilepsy could follow a head injury, couldn't it? Would Michael develop epilepsy?

Here is the specific anxiety, the relevant family history, and probably the reason for Michael's persisting symptoms. In prognosis, you must be prepared to be wrong sometimes. If you hedge your prognosis with qualifications you will never be wrong—or right. This situation demanded an emphatic and specific reassurance. "No, Michael will not develop epilepsy", supported, perhaps by a normal E.E.G. Michael's symptoms and mother's anxiety dissolved overnight. I do not know whether he developed epilepsy.

> Maureen aged six, started drinking a lot of water and passing a lot of urine (probably because of nasal obstruction and a dry mouth). Parental anxiety was disproportionate and Maureen's symptoms persisted. There was diabetes in the family. Specific reassurance on this point led to a rapid resolution of the symptoms.

But this article is about the prevention rather than the management of anxiety. There are many ways in which medical and nursing staffs can contribute.

Anticipate parental anxieties

As an everyday example, one would not give an injection of triple vaccine without explaining to the mother the nature of common reactions to the vaccine, and what action to take if they develop. She is then prepared for the upset if it happens and knows what to do about it.

Parents will begin to worry if their child is not saying any words by the first birthday, but they may worry about it privately for another year before asking advice. Opportunities can often be found for prophylactic reassurance in the field of child development. (I believe there would be less enuresis amongst school-age children if parents knew that 25 per cent of three-year-olds and 10 per cent of five-year-olds wet their beds.)

Explain procedures

The phenistix test (now replaced by the Guthrie test) has sometimes caused needless anxiety because the parents did not understand that *every* baby has this test. Without this information, they wonder why *their* baby has been selected, and any mention of mental handicap completes their dissolution.

The unexplained application of intelligence tests may, in the same way, suggest that the child's intelligence is suspect.

Monitor conversations

Needless anxieties are often generated by casual remarks being overheard (often misheard) and misunderstood. It is almost an insult to mention this in an article for professional people, but our guards drop all too easily when we start talking to somebody else in the clinic or on the ward.

> Mrs. H., who was expecting her first baby, attempted suicide. In the antenatal clinic her urine had been tested and someone had commented, "No casts or cells". Mrs. H. thought she heard a reference to "carcy cells"; she knew that carcinoma was cancer, put two and two together and made 65.

We have to be constantly on our guard not only about what we say and how we say it, but about what we *do not* say. The failure to refer to something can be interpreted by the anxious mind as very sinister.

Don't treat the normal

Many of the worries relating to infants and children relate to physiological conditions. Correct management is by explanation and reassurance. Unfortunately the treatment of self-limiting conditions and physiological variations, unless actively harmful, is associated with 100 per cent recovery and therefore tends to perpetuate itself. There is an almost irresistible urge to intervene. In hospital in the past this has largely consisted of snipping (tonsils, foreskins and lingual frænums); outside, it has been predominantly pseudo-orthopædic, in

the literal sense of trying to straighten children (more especially their legs) without recognising physiological knock-knees, bow-legs and flat feet. (I doubt if unnecessarily wedged shoes, exercised feet or even ultra-violet irradiated babies will be held against us on the day of judgment, but may we be forgiven mermaid splints.)

Resolve uncertainty speedily

A heart murmur is heard at a routine school or clinic examination. What does it mean? Usually nothing, but for parents there is an agony of suspense until a verdict is pronounced. My personal practice is to give these referrals top priority.

The baby who sweats at night is another urgency. In lay terms, night sweats = T.B. I have, in fact, never yet seen a child with T.B. who sweated at night. Nor have I seen a night-sweating baby who had T.B. Coughing blood is another symptom equated with T.B. in the lay mind, but in children it is rarely due to anything so serious.

Reassure effectively

A full history with special reference to family illnesses or deaths, and a thorough clinical examination, are necessary prerequisites to reassurance. Nothing enhances the doctor's esteem so much as thoroughness. Specific anxieties must be sought, but are not always immediately forthcoming. The contribution of the parents' anxieties to the child's illness must be assessed. The explanation which precedes reassurance must be tailored to the needs of the individual. Some parents want a mini-lecture with recommendations for further reading. Others just want to be told "Everything's all right." Finally, be on your guard.

> Stephen, aged 12, was referred to hospital because of recurrent abdominal pain which had gone on intermittently for a year. He looked a picture of health. Clinical examination, including microscopy of the urine, was normal. Enquiring into the family, it transpired that father had had a kidney removed for hydronephrosis two years previously. He was understandably anxious, and specifically so. Had Stephen got a hydronephrosis too? An intravenous pyelogram was done. He had.

Suggested Reading:

Apley, J., MacKeith, R. *The Child and his Symptoms* (second edition). Blackwell, Oxford and Edinburgh, 1968.
Gordon, I. "The Healthy Child: Its Many Disguises." *Brit. Med. J.* 1951, **1**, 611.
Illingworth, R. S. *The Normal Child* (fourth edition). Churchill, London, 1968.
Yudkin, S. "Six Children with Coughs." *Lancet*, 1961, **2**, 561.

This article first appeared in *West Riding Health Notes Supplement No. 19* distributed with *Health Notes* for August, 1970.

Child Health in Developing Countries

BERENICE BEAUMONT

In the U.K. last year we spent £40 per head on health; most developing countries only spend 20p. In the U.K., 90 per cent of people live in towns; in developing countries, the majority of the population live in rural areas. In these countries, one-half to three-quarters of all deaths occur in the 0—5 age group.

These three differences between developed and developing countries were taken as the starting point for a five-day seminar at the Institute of Child Health last autumn. The participants were doctors and nurses of many nationalities who had been engaged in medical work in undeveloped countries. The emphasis of the seminar was on small group interchange of ideas and experiences within a framework of lectures on different aspects of child care. Some of the more interesting points that arose are discussed here:—

Economic Priorities

Accepting that developing countries have only a limited health budget, the way in which available money is spent is critical. For example, in one West African country, a new and large Western-style hospital has recently been built. It stands empty—not only are there too few trained staff to man it, but the running costs cannot be supported. Two hundred and fifty health centres, built at similar initial expense, would not only extend the health facilities to a wider and more needy section of the rural community but would also require fewer specialised staff and less continuing expenditure. The cost of medical care given on an out-patient basis is only a fraction of that for in-patient care; and trials in Madras and other places have shown that even hernia repair operations and treatment of advanced tuberculosis can be effectively managed in this way. Adult out-patient clinics have been designed to take over the rôle of the general practitioner and casualty departments of this country, offering specific therapy or symptomatic relief.

The Needs of Children

Children's clinics were often developed along similar lines, but the needs of children are somewhat different from those of adults, since, although curative procedures can cut down childhood mortality by one-half, a further reduction in deaths can only be achieved by preventive and social measures such as teaching mothers simple, basic ideas about nutrition and hygiene, and giving immunisations. Among children in the West African village of Imesi, the preventable conditions of protein-calorie malnutrition, malaria, peritonitis, measles, tuberculosis and smallpox accounted for 46 per cent of all deaths, and a further 24 per cent from diarrhoea and pneumonia could have been much reduced by early recognition and treatment.

The Under-Fives Clinic

The Under-Fives Clinic attempts to cover this need to extend low cost curative and preventive care to a large section of the population. A mother who brings her sick child for medical attention is encouraged to attend this special clinic regularly, bringing all her children under five, even if she believes them to be healthy. Weighing is the cheapest measurement in medicine and is carried out on each visit to the clinic. The weight can be entered on a chart to give a visible record on which deviation from normal will be evident, and weight figures can be made meaningful by expressing them as percentage values for age. A falling behind in the weight curve indicates a need to discuss carefully with the mother her feeding methods, and for a few weeks a nutritional supplement may be given. Subsequent failure of adequate growth is then investigated more fully. Immunisations and simple treatment for infections or skin conditions can also be given when necessary. From discussions, it was apparent that in most cultures, mothers welcome a bottle of coloured medicine which can be taken home and passed around to be examined by other members of the village, as evidence that a visit to the clinic is worthwhile, even though it is the health education and the injections which offer the real preventive and therapeutic benefit. Several countries

A nurse helps a mother to weigh her child at a clinic in Uganda. Other mothers watch while they wait their turn. The posters on the wall will be used to illustrate a simple talk given by the nurse.

Photo: Alastair Matheson, U.N.I.C.E.F.

had adopted a system whereby the mothers were responsible for looking after the record card of her child's progress, and this was found to be more efficient and more economic than using a standard filing system and clerk.

Who Will Do The Work?

Finding staff for rural health clinic services appeared to be a universal problem. Doctors prefer to work in towns—for example, in the Sudan, one-third of all Sudanese trained doctors work in the capital, which supports only one-fifth of the population—rather than more remote areas where they feel too little thought or practical help is given with their difficulties. Attempts have been made to overcome these inadequacies. In Egypt, newly-qualified doctors are compulsorily posted to outlying regions for one or two years, but a team of doctors from the base hospital visits each rural centre regularly to deal with problems which arise and to hold a teaching session. Siting of new medical schools away from large towns and recruiting more medical students from those localities has also been suggested, but it was felt that schooling in the country districts would not yet provide a sufficiently high standard of education to precede full medical training.

The Role of the Doctor

The doctor, with his rather specialised knowledge, is not necessarily the most suitable person to undertake rural health care. Local people, locally trained, can provide a more continuous understanding contact with patients and their families than doctors seconded for short terms only, and their training can be orientated towards the particular aspects of their work. In Brazil, centres have been set up for rehydration of infants who have diarrhoea. Although each child is first seen by a doctor, scalp vein clinics are set up by local girls who have been carefully instructed in this technique but are otherwise poorly educated. Similarly, mothers visiting the Under-Fives Clinic will have their main dealings with a nurse, who is preferably herself a mother, and only that small minority of children with complicated or serious conditions will be referred by her to the doctor, who can then devote the rest of his time to tending and assisting other staff—as Spence has pointed out—"The purpose of a consultation . . . shall give explanation and advice . . . not the diagnosis or technical treatment."

Teaching mothers in child care should be an integral part of any contact with the health centre. For instance, simple posters can be displayed in the waiting areas, and a nurse can talk to groups of mothers there, giving guidance in choice and preparation of food, simple hygiene, and recognition of signs of illness in their children. Visual aids and demonstrations are the most effective means of presenting information, provided they are compatible with the setting in which they are used. One should not give advice on malaria prevention to African women using pictures of white families in an urban environment. If a child is admitted to hospital, the mother should be admitted too, as always happens in India, so that the learning

process can be continued. Unfortunately, erroneous impressions may also be gained. When seeing children being served food from tins, mothers may form the idea that protein foods cannot be prepared at home. It may appear that treatment consists only of giving drugs if other factors are not explained. If a technique such as transfusion is used and the child subsequently dies, it should be emphasised to the mothers that the treatment given was not the cause of death. Once the teaching process has begun, knowledge will be spread when mothers return to their village after a visit to the clinic or hospital. This visit may well have involved other village members in extra work to care for the family left behind and often to raise the money for medicines, and friends and relatives will be eager to hear all that has occurred.

In Madagascar, local people are organised into village health committees and receive a ten-day training course in public health education. Above, a trained mother seated at the table, demonstrates to other members of her village what she has learnt.

Photo: Alastair Matheson, U.N.I.C.E.F.

What More Can Be Done?

There are still many areas of child care where research has and should be carried on. In Bangalore, the most effective and economical method of BCG vaccination was studied. A mass campaign using loud-speakers to advertise the service resulted in a vaccination rate of 30 per cent, at a cost of 4p per person. House-to-house visiting with Heaf testing to detect susceptible people gave 70 per cent coverage

at a cost of 6p, but a similar programme with no Heaf testing resulted in a rate of 80 per cent at a cost of only 2½p. This method of immunisation could be extended to other parts of India. It now seems possible to combine smallpox vaccination with the BCG in a single injection. Evidence that the smallpox has taken is found at the injection site, and the result of the BCG confirmed by later Heaf testing. When new schemes for comprehensive care are introduced, feedback of information about their success can indicate areas of ignorance and superstition still to be overcome. The attendance rate at an Under-Fives Clinic could be low for one of several reasons. A mother may not be able to afford to pay a charge levied, or conversely may believe that free treatment cannot be good since their native doctors usually charge. The clinic might be too far away for her to visit easily or perhaps she fears the staff will laugh at her lack of education. She will almost certainly be anxious and frightened at visiting a strange place away from home, or believe that she is offending local spirits in doing so. There was much controversy at the seminar as to the rôle that local witch doctors and traditional herbal remedies would or should play. While some practices such as putting dung on the umbilicus of the newborn in Africa, or drinking a particular tea brewed in Jamaica, are known by us to be harmful, many native medicines have not been investigated and may continue to be useful in the same way that chemists here relieve the health service of an unnecessary load by dispensing aspirins.

Why Bother?

At the conclusion of the conference, I was left with the impression that the areas of child health programmes in most developing countries are similar, although local differences emerge in their execution. In the short term, if fewer children die as a result of better medical care, people will be encouraged to develop and support their new medical faculties. Studies in England at the beginning of this century, and later in Malta, suggest that there will be a corresponding voluntary reduction in the number of children born as parents see a greater proportion of their children surviving to adulthood. However, enthusiasm over the success of more immediate curative procedures must be used to get people to put interest and effort into meeting the long-term need to sustain this better standard of health in children. This is essential for the progress of a country in all areas, as was recognised by Lord Kitchener :—

"These people have been hungry, ill often for a very long time—does it really matter if they are hungry, ill and poor for a little longer while good foundations are laid?"

Further reading:

Bryant, J. "Health and the developing world." (1969.) Cornell University Press.

King, M. "Medical care in developing countries." (1966.) Oxford University Press.

I would like to thank Dr. R. MacKeith, who kindly made it possible for me to attend this conference, and subsequently provided help and encouragement.

Christmas Concert Review

It is perhaps unfortunate that over four months have slipped by without any record in these pages of the Music Club's Christmas Concert in Southwark Cathedral, in which Ian Starke conducted the official première of his Mass in A Major (the work had been first performed earlier in the week in Holy Trinity Church, Kingsway). The original review was apparently held up by the postal strike, and never reached its destination. The concert itself was also threatened by industrial action, but in this case it was the electricity men's work-to-rule. A power cut was expected on the night between 7 and 10 p.m., and emergency measures were drawn up to perform a variety of numbers by candlelight until power was restored, when the performance of the Mass could have proceeded. But fortunately the lights remained on, if somewhat dimly.

There is nothing underpowered about this setting of the Mass, however, which is Mr. Starke's first major composition. It is an extended work of about 45 minutes, and to most people's relief it did not prove to be one of these ultra-modern jumbles of sound. On the contrary, it is a carefully constructed piece and, as the quiet organ introduction and the soprano's lyrical "Kyrie" soon showed, has both feet firmly planted in the long tradition of Western music.

The scoring is for mixed choir, soprano and baritone soloists, and an orchestra tailor-made for the Guy's musical scene with trumpets, horns, trombones, tympani and organ. The absence of strings inevitably restricts the range of orchestral colour, but the composer was able, by skilful juxtaposition of contrasting episodes, to avoid any monotony of texture. The "Gloria" erupts on the scene with full choir and brass, this grand monument of praise giving way to a more tranquil section for choir and solo horn. In the succeeding sections, the brass instruments are employed in a variety of rôles, spiky in the "Laudamus Te" and most noble in the introduction to the "Domine Fili". The tympani enter menacingly, and as the baritone pleads for the remisison of sins, disquieting taps on the drum keep the tension high and the supplication more intense.

The "Credo", we are told, was written as an afterthought when the composition was almost completed. The choir sings in unison, at first alone and then with simple comments from the brass. Was the avoidance of harmony writing a matter of expediency, the desire to finish the work quickly, one wonders? If so, it turned out well, the unadorned melody gliding gracefully to a simple "Amen" close, and the whole slender structure providing a necessary contrast with the elaborate ending of the "Gloria", with oft repeated amens, and the majestic organ solo which introduces the "Sanctus".

A slow grandiose entry, quiet soliloquy and brief build-up again—and as the organ fades we become aware of the quiet intonation of "Sanctus" by a section of the choir. Its repetition cuts across the melody as it unfolds, and with only three voices per part, this delicate chorus is perhaps the most beautiful part of the entire work.

From unaccompanied plainsong to intricate harmony with angular brass interjections recalling Janacek—the work covers a wide scope of musical history and gives brief reminiscences of several composers en route (at one point, "like Verdi with accompaniment by Britten" was one imaginative comment overheard afterwards) but the overall effect is in no way derivative. Such eclecticism is not necessarily a weakness, but a stage that most composers have to go through, absorbing many influences whilst they synthesise their own distinctive style. One critic of an early work of (arguably) the greatest living composer, Britten, thought his sources ranged "from Prokofiev to Mascagni, from Rimsky-Korsakov to Gilbert and Sullivan", which is hardly a compliment!

The "Pleni Sunt Coeli", with its lively trumpet dance, and the vigorous "Hosanna" and "Benedictus", herald in a mood of increased optimism, and as the baritone and choir begin the final prayer for mercy, the "Agnus Dei", we feel something of the quiet confidence of faith. The soprano adds her plea, and although brass chords and ominous drum rolls remind us that peace of mind is not so easily obtained, the choir and soprano take us serenely to the quiet close.

Clearly, there is enough musical substance in this composition to stand repeated hearing, and it is to be hoped that future performances will be arranged, either inside or outside Guy's. It is a considerable achievement for a medical student to write such a work in his spare time; we await further compositions with interest.

In the first half of the concert, David Osborne played Bach's Prelude and Fugue in B Minor on the cathedral organ. Judging from the audience participation, his competent account of this glorious music did not capture everyone's attention, the offenders presumably viewing it as background music for the interval. The best that one can say is perhaps they were excited by the preceding item, "Joseph and the Amazing Technicolour Dreamcoat", a light-hearted retelling of the Bible story, satirising aspects of popular music over the last fifteen years. Very entertaining for both audience and performers, which I suppose is the main justification for the piece.

The three items in this concert are examples of the wide range of music-making at Guy's today. Various choir groups are now forming to rehearse folk songs, negro spirituals as well as more serious pieces for future concerts. A further performance of "Joseph" is planned for an engagement outside Guy's. It is hoped that everyone interested in singing and particularly those in their preclinical years (they are under-represented at present) will join one of these choir groups, so that the present healthy state can continue.

Howard Sowerby.

REVIEW

Guy's Hospital Theatre Club production of

The Knack

by Ann Jellicoe

Nancy (Caroline Prince), Tom (Bob Jezzard), and Colin (Keith Freeman) sing the "Blue Danube". (*Photo:* R. Wright)

The plot of "The Knack" is reasonably simple. Three young men share a flat. Tom, played by Bob Jezzard, outwardly manic, sparkles about the stage seemingly absorbed in his fanciful schemes for decorating the room, and his even more decorative fantasies. But despite his taste for extravagant imagery, Tom is the most wholly sane member of the group. Colin, played by Keith Freeman, is an intelligent young teacher, unsure of himself, and very concerned at his lack of "the knack" of mating girls. Tolen (Geoff Tobin—an eery resonance of names!)—is the over self-possessed playboy of the Western Ealing, who seems at first to be the annexe of a superfluity of knack. A provincial innocent—Nancy, played by Caroline Prince—stumbles upon the flat while searching for the Y.W.C.A., and stays long enough to unwittingly reveal the precarious nature of Tolen's knack, the unexpected success of Colin's lack, and the ultimate sanity of Tom.

In line with the witty programme graffiti by Peter Lewis, I can-

not resist a diversion into the realms of higher knacker metaphysics. Miss Jellicoe has managed expertly to solve apropos of everyday life, the unenviable existential dilemma which faces the writer of any successful Residents' Play apropos of hospital life. It is to be cast into the uncomfortable position of what Claud Levi-Strauss would have us call a *bricoleur*—one who by his bricolage must encode and re-code totemic messages using simple concrete material, such as that hallowed in popular hospital tradition, and to use these pre-constrained constituent units of myth, by exercising his only available liberty (that of deciding what to put in each available place) to provide a valid and powerfully significant sub-set of the micro-culture he inhabits! What price Harold Hobson now, eh?—well might Peter quote Milton's Simpson Agonistes.

This production, strong in direction and cast, must be accounted a most significant success and one that many of us will remember as one of the highlights of recent years of productions at Guy's.

Bob (*"When I die, I could be reincarnated as a sea anemone—it doesn't affect my attitude to death one little bit, but it does affect my attitude to sea anemones"*) Jezzard is to be congratulated on achieving a fine level of hypomania that genuinely managed that delicate balance between infectious bravura and the slightly embarrassing slapstick the part could so easily slide into. As the cuddly Dame Roberta Jackson was overheard to remark: "His *adagio* was good—but his *allegro* was fantastic". He obviously enjoyed himself, and so did we.

Keith (*" . . . should wear a carrier bag more often"*) Freeman triumphed in another potentially difficult rôle. He competently held our sympathy throughout his frustrated gaucherie, and effectively conveyed the essential niceness of the character, despite its overheated clumsiness. It is one thing to climb upon the amateur stage and play an unlikely hero; it is a much greater achievement to convincingly play an all-too-likely weakling.

Geoff (*"If I wanted . . . I could do it in about 85 seconds"*) Tobin gathered strength as the play got under way. Although at first his Tolen suggested a biologically unlikely mixture of the feline and the reptilian, and he hardly seemed fully comfortable in the part, he eventually showed more of the overweening masculine self-confidence the part needed. Some of the self-conscious subtlety was there. As the underlying vulnerability of the character emerged, he was on surer ground.

Caroline Prince, as Nancy, provided one of the most genuine and natural performances I have seen at Guy's in the last ten years. Her naive but would-be knowing girl from up-country was most convincing—one could almost hear the Kings Cross platform ticket in her skirt pocket. Her range of expression and movement promises well for the future.

One must also commend the girls—Bonnie Simons, Paula Cullen and Lesley Mason. Their brief but important appearances helped one

Tom, Tolen (Geoff Tobin) and Colin prevent Nancy from screaming that she has been raped. (*Photo:* R. Wright)

to understand Tolen's "I've had sufficient for today" tiredness. Ennui, the Eighth, perhaps?

The direction, by Jim Lewis, was unobtrusive but extremely effective. The pace never flagged, and the cast worked together with enviable smoothness; they remained alive, even when not having lines to speak, thus avoiding a very common failing of amateur productions. The set was simple, well planned, and entirely adequate. The amount of "business" indulged in by the actors was considerable, and remarkably successful. It must have been painstakingly carefully rehearsed, for it seemed uncommonly spontaneous and uncontrived. The essence of the production was its refreshing, unforced naturalness.

The Theatre Club have once again reminded us that despite some appearances to the contrary, talent, creativity and a strong sense of fun are still very much alive among Guy's students. Long may it continue to do so.

MICHAEL A. SIMPSON.

NURSING SECTION

Food for Thought

Only two or three years ago the question of whether or not nurses should pay for individual meals at the time they were taken was one of the burning issues of the day. As with most topics, the flame of argument gradually died low and became extinguished, and as a result a state of profound silence now exists.

Many hospitals at the time appeared to experience great pressure from their staffs and hurriedly organised a system for paying as they ate. Others refrained and to this day have not changed their methods.

Food, of course, provides a constant topic for discussion and criticism in every institution. In addition, no two establishments will offer the same standards. Therefore in hospitals, staff will receive different quantities of meals although by government decree they pay the same emoluments. One can, therefore, appreciate that in the hospitals where the meals offered are of poor quality, the pressure exerted on the authorities to establish a system whereby payment for meals is not compulsory, will be greater than in those where a conscientious attitude is displayed.

Despite all this, however, what happens when a pay-as-you-eat scheme is introduced? Firstly, of course, the student nurse will be financially much poorer. Their emoluments are heavily subsidised at present, and they are the greatest losers in the new system. Consequently, they do not eat properly, and some hospitals have noticed a marked rise in the sickness rate. Surely this is not right. No nurse in training should have to pay for her meals in this way. If this system has to be introduced, should it not be with the exemption of students?

Let us consider the case of trained staff. Currently, a ward sister pays around £28 a month for her board and lodging. Many feel very strongly that they would gain considerably by paying for meals as they had them. Would this, in fact, be the case? If one is non-resident it is quite difficult to exist on this amount. In addition, some hospitals have been unable to maintain their former standards at the same time as charging an economical amount for each meal.

Surely this is yet another area where hasty action is not necessarily wise. Might it not be better to consider seriously whether a change really will be an advantage? The wind of discontent blows fiercely through this country at present. We are all subject constantly to far-reaching alterations. Could not the hospitals call a halt occasionally?

There is a popular rumour to the effect that good food promotes good health. Surely this is imperative for nurses. People will normally take that for which they do not have to consciously pay. Should not the hospitals who so rapidly changed, reconsider their policy? If one is non-resident one pays £5 per month for food. This means that the daily main meal costs 25p. Where else can one obtain a three-course meal for this amount? Maybe this could provide food for thought!

CORRESPONDENCE

The Guy's Choir

SIR,—I should like to take advantage of your columns to congratulate the choir on their contribution at the recent Memorial Services held for the late Dr. W. H. H. Merivale and Professor De Navasquez. The beauty and dignity of the music on each occasion made a profound impression on all who attended.

Yours faithfully,

PHILIP J. HELLIWELL,
Superintendent.

Superintendent's Office,
Guy's Hospital,
S.E.1.

Clinical Day

SIR,—The article in your issue of 27th March, reporting the Clinical Day in the Dental School, showed the enthusiasm of the Guy's Alumni. Despite the postal strike and the decaying state of the present building, it was probably one of the most successful meetings for many years. I would like to thank the dental technicians in several departments whose hard work and enthusiasm contributed very considerably to the success of many of the demonstrations.

Yours faithfully,

W. J TULLEY

Department of Orthodontics
Guy's Hospital
London Bridge, S.E.1.

Mr. Dudley

SIR,—Mr. Dudley's many friends throughout Guy's medical and dental fraternities will be most sorry to hear that, as a result of his recent illness, he has decided to retire. He has long been a well known figure in this community, and I am quite sure that there are many people, both those working here at the moment and others, who have known Mr. Dudley in the past years and will wish to signify their affection and admiration of him in some suitable manner. We, the undersigned, will be most pleased to receive any contributions and suggestions as to how Mr. Dudley's many friends would like us to mark this occasion in his life.

Yours sincerely,

ROGER WARWICK,
Anatomy Department
J. OSBORN,
Dental Anatomy
V. BENNETT,
Physiology Department

Anatomy Department,
Guy's Hospital Medical School,
London Bridge, S.E.1.

NOTICES

CHARITY SPORTS AFTERNOON

2.15 p.m., Sunday, 25th April

at

HONOR OAK PARK

FANCY DRESS FOOTBALL MATCH

Angels XI v. Soccer Club XI

TUG-OF-WAR

Rugby Club v. Boat Club

LADIES' FOOTBALL MATCH

Crystal Palace Ladies' F.C.

v.

Guy's Theatre Nurses.

Referee : DAVID WEBB (Chelsea)

Admission by Programme : 12p.

Bar and Refreshments.

Proceeds from the afternoon will be given to the Evelina Children's Hospital for the purchase of toys for the children who are patients there.

SOUTHWARK CATHEDRAL CHOIR

A NEW MUSICAL APPROACH AT SOUTHWARK CATHEDRAL

We are forming a voluntary choir under the Director of Music, E. H. Warrell—14 male singers (under the age of 40): four alto, four tenor, six bass—to join with the present boys' choir, and to provide on one week-day evening, music for worship appropriate to the 13,000 who cross London Bridge, and for the main act of worship at 11.00 a.m. on Sunday.

Good standard of sight reading and musicianship and sympathy, with a versatile approach to Cathedral music and worship essential. Apply by 30th April : The Provost, The Chapter House, St. Thomas' Street, S.E.1.

MUSIC CLUB CONCERT

GUY'S HOSPITAL CHAPEL

TUESDAY, 11th MAY, 6.00 p.m.

Once again the whizz-kids of the Music Club Committee have arranged a one-hour show for our delight and edification. Once again the Revd. Kempster has been kind enough to allow the Chapel to be used for this purpose.

The programme will consist of several short choral pieces, including some old favourites, some modern horrors, and an interesting piece by Joubert ("the one with the fabulous bass part").

Not content with one choir, a second, more specialised choir, has been fielded, and is going to perform Negro spirituals and other oddments. Then there will be the lovely Veronique with her folk music, and, as an antidote to all the shouting, a little quiet organ music from Ian.

Once again we hope that our usual admirable audience will attend, together with some of those who have so far not dared to trust the Music Club and its activities.

ENTRY IS FREE.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL AND SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited for the post of **Paediatric Registrar** (middle grade) to the Board of Governors of Guy's Hospital and the South-East Metropolitan Regional Hospital Board with duties from 1st October, 1971 for two years. The appointment which will be made jointly by the two bodies concerned will be held in the first instance at the Royal Alexandra Hospital for Children, Brighton, until 30th September, 1972, and at Guy's Hospital from 1st October, 1972 to 30th September, 1973. Forms of application are obtainable from and should be returned to the Superintendent, Guy's Hospital, London, S.E.1, not later than **14th May, 1971.**

GUY'S HOSPITAL AND SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited for the post of **Anaesthetic Registrar** to the Board of Governors of Guy's Hospital and the South-East Metropolitan Regional Hospital Board with duties from 1st October, 1971 for two years. The appointment will be made jointly by the bodies concerned and will be held in the first instance in the Brighton and Lewes Group of Hospitals until 30th September, 1972 and at Guy's Hospital from 1st October, 1972 to 30th September, 1973. Forms of application are obtainable from and should be returned to the Superintendent, Guy's Hospital, London, S.E.1, not later than **14th May, 1971.**

GUY'S HOSPITAL AND SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited for the appointment of **Registrar** in Psychiatry (middle grade) to the Board of Governors of Guy's Hospital and the South-East Metropolitan Regional Hospital Board, with duties from 1st October, 1971, for two years. The appointment which will be reviewed at the end of the first year will be made jointly by the bodies concerned and will be held at St. Olave's Hospital, S.E.16, and Bexley Hospital Kent. The Department of Psychological Medicine at St. Olave's Hospital offers in-patient, day-patient and out-patient facilities in a busy general hospital. Opportunity will be provided for study and experience in developing community service involving links with Guy's Hospital. Experience in special problems and rehabilitation will be provided for study and experience in developing community service involving links with Guy's Hospital. Experience in special problems and rehabilitation will be provided at Bexley Hospital, which is a modern adult psychiatric hospital. Forms of application are obtainable from and should be returned to the Superintendent, Guy's Hospital, London, S.E.1, not later than **14th May, 1971.**

GUY'S HOSPITAL
JUNIOR STAFF APPOINTMENTS 1971—72

Applications are invited for the following appointments to the Junior Staff of the Guy's Hospital Group, commencing on 1st October, 1971, for the session 1971/72. Forms of application are obtainable from and should be returned to the Superintendent, not later than **14th May, 1971.**

Anaesthetics
Senior Registrars 3
Registrars 5

Appointment to these posts may involve duties at St. Olave's and New Cross.
Registrar 1

This appointment is under the exchange scheme and will be made jointly with the South-East Metropolitan Regional Hospital Board with a two-year tenure of the post. Applicants will be required to spend one year in the Brighton and Lewes Group.

Cardiology
Senior Registrar 1
Child Psychiatry
Senior Registrars 2
Registrar 1
Clinical Pathology
Senior Registrar 1
Registrars 3
Junior Registrars (S.H.O. Grade) 4
Two will be at St. Olave's Hospital.
Senior Registrar (Haematology) 1
Dermatology
Registrars 2
Diagnostic Radiology
Senior Registrars 3
Registrars 2
Trainee Registrar 1
Ear, Nose and Throat Surgery
Registrars 2
Medicine
Senior Registrar 1
(locum for one year)
Registrars 8

These appointments will be for one year in the first instance. The successful applicants may be required to spend part of their time at hospitals in the Group or to work in certain special departments at Guy's.

Junior Registrars (S.H.O. Grade) 7
The successful applicants may be required to spend part of their time at hospitals in the Group.

Neurology
Senior Registrar 1
Obstetrics
Registrar 1
Opthalmology
Senior Registrars 2
(part time)
Registrar 1
(part time)
Junior Registrar (S.H.O. Grade) 1
Orthopaedics
Registrars 2

Appointment to these posts may involve duties at New Cross Hospital.

Orthopaedics and Casualty
Registrar 1
Paediatrics
Senior Registrar 1
Registrar 1
This appointment is under the exchange scheme and will be made jointly with the South-East Metropolitan Regional Hospital Board *with a two-year tenure of the post. Applicants* will be required to spend one year in the Brighton and Lewes Group.
Physical Medicine
Registrars 2
These appointments will also involve duties at New Cross and St. Olave's Hospitals on a day-to-day basis.
Psychological Medicine
Registrars 3
Registrar 1
At St. Olave's Hospital.
Registrar 1
St. Olave's and Bexley Hospitals.
Radiotherapy
Senior Registrar 1
Registrar 1
Surgery
Senior Registrars 3
Registrars 3
Junior Registrars (S.H.O.) 4
Appointment for one year in the first instance, renewable. Two posts will rotate with the Maudsley Hospital.
Thoracic Surgery
Senior Registrars 2
Registrar 1
Urology
Senior Registrar 1
Venereology
Senior Registrar 1
(part time)

GUY'S HOSPITAL MEDICAL SCHOOL
JUNIOR STAFF APPOINTMENTS—1971-72
Applications are invited for the following appointments to the Junior Staff of the Medical School, for the session 1971-72, commencing 1st October, 1971. Forms of application are *obtainable from, and should be returned to the* Dean not later than 14th May, 1971.
Medicine
Lecturer 1
Junior Lecturer 1
Obstetrics and Gynaecology
Lecturer 1
Surgery
Lecturers 2

FELLOWSHIPS AND STUDENTSHIPS

The Adrian Stokes Memorial Fellowship
The Fellowship is open to qualified Medical Practitioners or Graduates in Science, Pathology or Bacteriology. Applicants must be anxious to carry out further study in Pathology or Bacteriology in any of their branches. The Fellow is required to carry out this study during a period of not less than six calendar months in his year of tenure at a University, School or Hospital or other institution, subject to the approval of the School Council, except the School in which he has received his medical or scientific education. The Fellowship is of the value of approximately £460.

The Greville Studentship
The Greville Student, who is required to devote himself to original investigation in connection with the subject of cancer, holds the appointment for a period of two years, renewable annually for a period of three years, making five years in all. The Studentship is of the value of approximately £45 per annum.

The Hilda and Ronald Poulton Fellowship
The Hilda and Ronald Poulton Fellow carries out research in the Department of Medicine under the supervision of the Director and the object of the Fellowship is to increase the knowledge of the origin, progress, treatment and cure of obscure diseases in man. The Fellow holds the appointment for two years, and is eligible for re-election. The Fellowship is of the value of approximately £250 per annum.

PASS LIST

UNIVERSITY OF LONDON

M.D.

A. J. U. Anderson — M. N. Maisey
M. B. Conran

Ph.D.

A. K. Chowdhury — D. L. Newman
B. D. Cox — Hermione A. Simmonds
J. W. Dellimore — J. F. Tucker
Khin U May

ROYAL COLLEGE OF PHYSICIANS OF ENGLAND

M.R.C.P.

T. S. Brown — C. L. Newman
A. Calin — J. G. Pickering
Mary T. Cunningham — J. H. Tripp
F. F. T. Djabanor — N. M. White

ROYAL COLLEGE OF SURGEONS OF ENGLAND

Primary F.R.C.S.

M. C. E. Hutchinson — I. H. K. Scott

F.F.A.

N. S. Faithful

ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

F.R.C.O.G.

A. S. F. Butcher — G. F. Falconer
Sleem F. Din

F.R.C.Path. March, 1971

Dr. A. L. Jeanes

EXAMINING BOARD IN ENGLAND

Final L.R.C.P., M.R.C.S.

Medicine

Linda J. Addison — J. C. L. Logan
A. I. Attwood — R. H. Mackay
C. C. Baker — S. J. D. O'Keefe
S. E. T. Bowden — J. Rawlinson
A. J. Camm — C. G. Rowland
S. R. D. Coles — R. G. Speight
B. G. A. Dick — R. S. Stanley
N. P. D. Downing — G. C. Taylor
R. A. Gude — D. V. P. Thomas
J. G. G. Hanley — Rosalind J. Thorburn
Gillian L. Hoare — A. R. Valentine
S. D. Horsley — D. E. Ward
Frances E. Jones — J. A. H. Wass
N. A. G. Jones — Deirdre C. T. Watson

Midwifery

Margaret L. Cann — E. G. Latimer-Sayer
N. P. D. Downing — D. Macdiarmid
W. Edmonds — M. A. Mansell
A. Fenn — B. V. Martindale
L. P. Harrison — R. S. Stanley
G. M. A. Heaton — A. R. Valentine
D. M. Hunt

Pathology

A. J. L. Brain — D. M. Hunt
Penelope Brain — Alison Ironside
Margaret L. Cann — E. G. Latimer-Sayer
N. P. D. Downing — B. V. Martindale

P. R. Evans
A. Fenn
L. P. Harrison
G. M. A. Heaton
Gillian L. Hoare
P. Matthews
T. de F. Mendis
G. L. Pryor
A. J. Scourfield
G. C. Taylor

Surgery

J. L. Bates
D. Bellamy
A. J. Camm
Irene D. Cormac
Rosalind C. S. Dow
H. K. C. Fan Lun
Angela W. Godsmark
T. W. Higenbottam
Alison P. Hill
A. V. A. Lalani
Sarah A. Lange
Vivien A. Leask
D. Macdiarmid
M. A. Mansell
N. R. T. Pashley
G. Peters
P. W. L. Ribet
A. M. Ross
J. R. M. Ross
Loretta Salter
R. S. Stanley
Morna J. Van Essen
R. J. Wainwright
D. E. Ward
R. D Ward

PERSONAL

DENTAL SURGERY, near Guy's. Associate/Assistant required May to join Guy's man in well-equipped practice. Tel: 237 2085.

SWANSEA—Dental Assistant/Associate required for modern practice with a view to fee-sharing partnership. Guy's man preferred. The practice is in the best part of city's surroundings are delightful. Yachting-golfing and beautiful bays only ten minutes away. Telephone evenings: Swansea 21405.

THREE-MAN entirely private dental practice in Camberley, Surrey, requires assistant aged 25—30 with view to early partnership to replace recently retired senior partner. Experience of crown and bridgework an advantage. Telephone: Camberley 63196.

ACCOMMODATION available in Cavendish Square, London, W.1. Consulting rooms and/or dental surgery available immediately. Box No. 4/4.

CHANGES OF ADDRESS

Dr. K. R. J. Coates, P.O. Box 320, Port MacQuarie, N.S.W., 2444, Australia.

Surgeon Lieutenant-Comdr. and Mrs. W. R. Esson, 18, Smugglers Way, Rhu, Helensburgh, Dunbartonshire, Scotland.

Dr. and Mrs. David J. Ewing, 100, Redford Loan, Colington, Edinburgh, EH13 0AT. Tel: 031-441 3970.

From 26th April, 1971. Dr. and Mrs. Philip Helliwell, "Brettes", Monks Eleigh, Nr. Hadleigh, Suffolk. Tel: Bildeston (04495) 637 and temporary London Address:—Top Flat, 13, St. Thomas' Street, London, S.E.1. Tel: 407 7600, Ext. 750.

Mr. and Mrs. A. F. Paton, Smocombe House, Enmore, Bridgwater. Tel: Spaxton 384.

Dr. and Mrs. G. D. Thomas, "Penderyn", 48, Fields Park Road, Newport, Mon., NPT 5BH.

Dr. and Mrs. P. A. D. Williams, 58, The Brow, Woodingdean, Brighton, Sussex, BN2 6LN.

BIRTH

ESSON—On 29th March, 1971, at Queen Mother's Hospital, Glasgow to Elizabeth (née Storrs Fox, S.R.N., S.C.M.), and Walter Esson, a son, Donald Alasdair Walter Storrs, brother for Fiona.

PAPERS BY GUY'S MEN

Baker, R. W. R. and others. Improvement in nerve conduction following treatment in newly diagnosed diabetics. *Lancet*, 1971, **1**, 428.

Calne, R. Y. Organ transplantation between widely disparate species. *Transplantation Procedings*, 1970, **2**, 550.

Collins, J. V., Evans, T. R. and Clark, T. J. H. Basic equipment for medical intensive care units. *Lancet*, 1971, **1**, 285.

Collins, J. V., Clark, T. J. H., Evans, T. R. and Riaz, M. A. Central venous pressure in acute myocardial infarction. *Lancet*, 1971, **1**, 373.

Folb, P. I. and Trounce, J. R. Immunological aspects of candida infections. *Lancet*, 1971, **1**, 594.

Hayward, J. L. Hormones and human breast cancer : an account of 15 years' study. *Recent results in cancer research*—31. Heinemann, London, 1970.

Healey, T. E. J. and another. Intravenous diazepam in the apprehensive child. *British Dental Journal*, 1971, **130**, 25.

Healey, T. E. J. and another. Laryngeal competence under diazepam sedation. *Proceedings of the Royal Society of Medicine*, 1971, **64**, 85.

Mackeith, R. and another. *Infant feeding and feeding difficulties, 4th edition.* Churchill, London, 1971.

Rees, R. J. W. and another. Experimental human leprosy in the mouse. *Glaxo Volume*, 1971, **no. 34**, 7.

Robinson, R. O. *Medical emergencies, diagnosis and management.* Heinemann, London, 1970.

GUY'S HOSPITAL GAZETTE

EDITORS N. D. S. BAX and A. M. TURNER
NEWS EDITORS R. M. DARLING and J. L. LEWIS
SPORTS CORRESPONDENT A. M. ROYSTON
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TEN PENCE VOLUME 85 NUMBER 2160

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Sex Education

During the past two weeks some journalists have had a news item that has obviously kept them happy. The Birmingham sex education film has provided many with a source of income.

In the furore of whether or not it is decent or in context to see a woman masturbating, the essentials of the matter of sex education seem to have had a red line put through them. In true tabloid page journalistic style the hunger has been sated before the appetite has been whetted. Everybody should be given information concerned with reproduction both about how and how not to have children. Although that is still disputed by many, it is quite rightly generally accepted. One of the prime aims of any sex education scheme must be to dispel anxieties and correct false ideas. It is the mysticism of sexual behaviour that is great in a young person's mind and whilst its elucidation is necessary no lack of respect towards the children must be shown by the teacher. Thus an extremely difficult balance must be obtained between instruction at various stages throughout a child's life and discouragement of morbid ideas about sex. A pornographic illustration that masturbation will not stunt one's growth, rot the brain or make one go blind is not the most tasteful of methods to tell youngsters that this particular activity is not unnatural.

It is the frustrations of sex educationalists that have been shown so clearly in recent weeks. Opposition to imparting information about subjects that have by fashion been suppressed is both difficult and tedious to overcome. Changes are implemented at an exasperatingly slow rate, but tasteful and well timed education of children now will make everybody's task easier in the generations to come. One method of overcoming parental fears of the form and content of sex education could be by using television to show the educationalists'

intentions. Parent-teacher associations are undoubtedly very useful but the illegitimate births and abortion statistics show that the people who need help are unlikely to have parents who take an active interest in their children's education.

Illegitimate births are rather like prostitution—neither can be stopped. Abortions have in a small part helped to reduce mental, physical and in many cases material misery caused by some pregnancies. One method of helping is by subtle, tasteful and above all respectful sex education.

Chaos is come again

We must congratulate several clinical teachers and members of the Medical School alike for standing out, in this day and horridly cost-effective age, alone, albeit absurdly, against the demands of the modern school for minimum of effort for maximum returns. The award for addle-headedness comes to Guy's on this particular occasion for its oustanding recognition that, in medical education, as in all things, the approach to the truth is many-sided and there is no one way to train good doctors. Thus we have a medical school running lecture courses and the firm system producing rounds, out-patient sessions, operating lists and talks on clinical matters, each working quite independently of the other and, considerably more often than never, clashing in their timetables.

It is tedious but perhaps acceptable to spend the first two weeks of the firm re-arranging the timetable so that it is possible for many of the firm to go to many of the rounds and lectures, but the situation does arise when clinical teaching coincides in time with a medical school lecture, which has a compulsory multiple choice examination at the end of the course. On such occasions firm teachers claim that their practical teaching is much more important, and lecture material is better absorbed from books. It is the old thesis that lectures are scrawls that pass from a lecturer's notebook to the student's, passing through the mind of neither. There is also the feeling that if someone has to change it should not be the clinicians all the time. Well, those raise three points. If lecture material is better absorbed from books why does everyone rely on lecturers at one time or another? The second, and this is well known to all who have taken multiple choice examinations, is that the examinations are based on the course and not on any well-known textbook, and disagreements are common. Thirdly, is there any reason why there has been no move to resolve these clashes of attitude to medical teaching to provide an integrated course?

GUY'S DIARY

MAY

10 M 1.00 Dental Clinical Lecture.
"Continuing Education after Qualification."
Professor NAYLOR.

11 Tu 1.00 Clinical Lecture.
"Thyroid Disease in Children."
Dr. STIMMLER.

13 Th 1.00 Clinical Lecture.
"Hypertension and the Arteries."
Dr. I. McD. G. STEWART, Consulting Physician, Victoria Hospital, Blackpool.

14 F 1.00 Clinical Lecture.
"Antibiotic Therapy."
Dr. MACLEAN.

2.15 Combined Round.
Dr. MACKEITH and his firm will present a case of Meningomyelocoele.

17 M 1.00 Clinical Lecture.
"Intensive therapy of the failing cardiovascular system."
Mr. YATES.

18 Tu 1.00 Clinical Lecture.
"The Ischaemic Leg."
Mr. ELLIS.

21 F 2.15 Combined Round.
Dr. STEVENS and Dr. POWELL-JACKSON will present some non-metastatic complications of Malignant Disease.

NEWS IN BRIEF

Reg Brake

It is with great sadness that we announce the death of Reg Brake, the late landlord of The Miller.

He was a well-known figure in the Guy's community and showed great interest in the Hospital's activities, especially those of the Rugby Club. He was elected the President of the Tankards in 1957, two years after coming to The Miller. At this time The Miller was part of the Hospital, both in site and by the nature of the landlord.

The Miller has always been "Guy's pub", especially so before its move to the other side of the street. Reg was always part of Guy's and will be remembered as such.

We offer our sincerest sympathies to his family.

The Students' Club Council

The Students' Club Council recently completed its annual reconstruction with the election of Miss A. Dick and Mr. C. G. Chinnery to represent the senior 2nd M.B. students. The following are the officers of the Students' Club:—

President: Mr. R. G. Beard.
Secretary: Mr. I. H. Grenby.
Treasurer: Professor R. D. Emslie.
Student President: Miss L. K. Hampson.
Student Secretary: Mr. J. P. C. McGlone.
Student Treasurer: Mr. A. N. Rogers.

At a recent meeting of the Council, the following Representatives and Sub-Committees were elected:—

(a) Student Representatives on the Club's Union Council: Miss A. Dick, Mr. R. S. Weedon.
(N.B.—In addition the Student Secretary, Mr. J. P. C. McGlone, is a member ex-officio).

(b) Officers of the Book Exchange: Mr. N. McLeod and Mr. S. Miller.

(c) Entertainments Sub-Committee: Chairman, Mr. C. G. Chinnery; Social Secretary, Mr. D. J. Arnold; Miss M. P. Hooley, Mr. R. Ashman, Mr. D. J. Jones.

(d) Medical School Catering Sub-Committee Representatives: Miss J. A. P. Leithead, Mr. J. N. E. Buckley.

(e) Wine Sub-Committee: Bar Secretary, Mr. T. J. Cox; Mr. R. Ashman, Mr. J. P. C. McGlone.

(f) Members to assist the Senior Secretary in the running of the East Wing: Miss A. Dick, Mr. R. Ashman, Mr. A. R. Rogers.

(g) Billiards Room Sub-Committee: Mr. T. J. Cox, Mr. K. Freeman.

(h) B.M.S.A. Sub-Committee: Mr. T. J. Goulder, Mr. R. W. M. Wright.
(N.B.—In addition, the Student President, Miss L. K. Hampson, is a member ex-officio.)

(i) Medical Students' Stroll Representative: Mr. D. R. Cottam.

(j) Student Representatives to sit on the New Hostels Working Party: Miss L. K. Hampson, Mr. K. Freeman, Mr. A. R. Rogers.

(k) Council Members to be U.L.U. Representatives: Miss L. K. Hampson, Mr. D. R. Cottam, Mr. T. Kidger.

(l) Student Representatives on the School Council (Academic Board) of the Medical School: Miss J. A. P. Leithead (Dental), Mr. A. R. Rogers (Medical).

(m) Student Representative on the Dental Council of the Dental School: Mr. T. Barnes.

(n) Sub-Committee in charge of duplicating: Miss M. Hooley, Miss J. A. P. Leithead, Mr. D. J. Jones.

(o) Council Member to be in charge of production of the Students' Club Handbook: Duplicating Committee.

Unseen Talents

In the last issue of the *Gazette*, the recent Theatre Club production of "The Knack", by Ann Jellicoe, was reviewed very favourably. Perhaps at Guy's there lurks much unseen and frustrated talent but many people fear the Theatre Club's auditions or else they regard it as a closed shop.

The July production is intended to provide an opportunity for on- and off-stage talent to emerge; it consists of three one-act plays, each with its own producer and cast. In addition, the Theatre Club intends to run workshops which will consist of play-readings and illustrated talks by guest speakers. Anyone associated with Guy's who has ideas or interests in running workshops, or in acting or producing is strongly encouraged to contact Paul Gartell in the East Wing.

Research News: Ultrasound

Interesting research is being carried out by Dr. Mary Dyson and Dr. J. B. Pond, with Professors Warwick and Joseph of the Anatomy Department, on the effect of ultrasound on tissue regeneration.

This line of research was started as a result of a series of coincidences: firstly, a good experimental model for the study of regeneration had been developed by Professor Joseph, by which rate of regeneration could be measured accurately; secondly, an ultrasonics unit had been established by Professor Warwick; and thirdly, a search through the literature revealed that (a) at certain doses within the therapeutic range, ultrasonic irradiation stimulated metabolic rates by

increasing enzyme activity; and (b) ultrasound stimulated growth of young plants, implying an effect on anabolic activity. It was decided to investigate whether ultrasound had a similar stimulatory effect on tissue growth in animals.

The experimental model consists of removing a square centimetre piece of tissue from the full thickness of a rabbit's ear and the measurement of the regeneration which develops at the excision site. It was found that ultrasonic irradiation increased the rate of regeneration at low doses. This was associated with a slight rise in the temperature of the regenerating tissue, although by maintaining the tissue temperature constant and using different ultrasonic regimes it was shown that the effect on regeneration was not mediated via the temperature rise. It is thought that the most likely mechanism is by means of "cycle-averaging effects": as the irradiated tissue is compressible, a component of the mechanical force exerted by the irradiation does not return to zero at the end of each cycle. This produces a steady, unidirectional streaming in those tissue elements which are free to move, probably both inside and outside cells. It is thought that this streaming may enhance diffusion rates and influence molecular interactions, important in growth processes.

The uses of ultrasound in physical medicine include its use as an aid to the clearing of fibrous adhesions from regions of surgical intervention, and also to soften the frequently highly collagenous scar tissue formed after burning and laceration of the hand. In this connection it was found that ultrasound interferes with deposition of collagen fibres, possibly by reducing the bond formation involved in polymerisation, and produces a temporary reduction in the quantity of mature collagen formed, which reverts to normal when ultrasonic irradiation ceases.

Ultrasound was also found to increase the uptake of tritiated thymine by regenerating tissues, implying a rise in the rate of DNA synthesis.

It is hoped that the effect of ultrasound on tissue regeneration may have therapeutic potential, for ultrasound has several advantages: its effects are purely local, not systemic; it has no known harmful side-effects at its optimum dose; the optimum dose can be produced by ultrasound machines already available in physiotherapy units.

Under certain conditions, ultrasonic irradiation has also been found to have an effect on blood flow, producing temporary arrest in red cell flow in vivo. This would result in reduced oxygen supply, an effect which could possibly be used clinically to produce temporary local hypoxia. This may be of value in wound healing, as a means of modifying scar tissue production, for collagen formation is known to be highly sensitive to oxygen availability.

The Rites of Erythrocytes

"The adult mature red cell is metabolically underprivileged."
(Valentine *et al* 1966)

Red cells do not, cannot and must not consume the oxygen which they obediently carry to the finger-tips and the bowels of the bowels. Physiological order depends on this generous and selfless act. Fetching, carrying and unloading the precious cargo down a sigmoid shute and then back for more like six million Ancient Mariners per cubic milleliter. Engaged throughout their first and last hundred days in subserving needs which they do not share.

If deprivation is to lack what others have, then the red cell in lacking a co-ordinated system of oxidative enzymes is deprived of the ability and need to consume oxygen and thereby set apart from the metabolic mainstream. What would they do with the oxygen if they had it for themselves? After all, the red cells have redox systems served by the hexose monophosphate shunt, which remove electrons from ferrous iron and the Central Intelligence Agency calls that oxidation. You follow me? "O" Level stuff which everybody knows and yet so clearly preposterous. Physiological indoctrination can result in a philosophy alarmingly akin to apartheid. The mindless and the powerless feed the fires of their own destruction, satisfied and calmed with rubbish about fatherland, paradise and physiology. What is one red cell to the greater glory of the body?

The standard bearers of the new erythron are on the march to get their erythrocytes' rights and as for the oxidation business, you can stuff the electrons up your hexose monophosphate shunt dearie. And if the rest of the body asphyxiates in the process, to hell with it.

Co-ordinated systems are served by parts which have little independent reality. The reward and penalty is progressive loss of identity in speed and efficiency up to the moment of despair. Then suddenly, in the most unexpected place, independence can be reclaimed, for after all, who wants to share despair? Desperate people can escape from the frustration of anonymity by creating a catastrophe which no one can ignore. The pathways towards catastrophe are deviations from appetites and compulsions upon which the system thrives. Revolution is the catastrophe in the ordered life-style served by advertising. Advertising shows a man what he could be; what he lacks in being himself. He is persuaded that he wants what he lacks. The wants are transcribed into needs and the needs are compelling. The needs proliferate to a point beyond conceivable fulfilment. From that point onwards subservience is no longer enlightened self-interest, it is slavery.

But of course it is not that simple; not just ASLEF working to rule and women's lib but Soledad Brothers and Arab refugees violated and dying. For them the future is now or not at all. A future in the mind, a future in turmoil—forget about the long-term plans to

attenuate social injustice, there isn't time for the men who will hang tomorrow. Is hope only in the hearts of the dispossessed, steeled in revolt and in the plans of fascists devoted to keeping power firmly in their grasp? Bobby Seale, Ronald Reagan, Habash and Menachem Beigin. Names which resound against a background of silence and that silence is complicity. Your silence. My silence. We rest in comfort on our privilege, deny responsibility in an order, oh! far too complex for us to intervene. But it is a responsibility of privilege to strike out against injustice. We possess the liberty to be liberal, the means to be informed and the power to be corrupt. Abdication from responsibilities, in whatever form is a corrupt act.

If reasonable people deny the existence of crucial issues these will be embraced by passionate extremists, facing each other across a vortex of hatred into which we shall all be dragged protesting in vain of our innocence.

If a hundred days is all you have, or seventy-four years for that matter, the least you can harvest is the conviction that you did the experience justice. There is enough time to test the options and to narrow the functions and yet to abdicate nothing. However long death will last, it will surely be far too long to spend in regret. Let it be heard that the red cell is not metabolically under-privileged but has iron in other fires, which burn without oxygen perhaps. We are victims only if we do not feel and enjoy the ambiguities of our situations and harbour only the conviction that we have suffered deprivations which merit the apocalypse.

Valentine W. N. *et al, American Journal of Medicine* 1966, **41**, 27.

M.S.R.

NOTICE

Human Chess

One creature the world has not forgotten is Julie Ege. She and the two finalists of the last British Chess Championship, R. G. Wade, the champion, and R. Keene, runner-up, are playing animated chess in Paternoster Square, by St. Paul's Cathedral, on Saturday, 14th May. The pieces are thirty-two girls from the sixth form of Alwyn Comprehensive School, Southwark, who will be enacting the moves in costumes provided by the Royal Ballet Company in the first human chess game to be played in Britain since the Festival in 1951. There is no need to pawn your jewels since entrance is free and spectators will not be rooked. There will be a collection of money (yes, and cheques, mates) for the Spastics Society during the game, which will start at twelve noon. The Spastics Society provide great financial support for the Paediatric Research Unit in Guy's.

Advance in the Treatment of Professional Football Injuries

by A. WOOLSTONE

Thanks are due to Miss B. Graveling, M.C.S.P., Superintendent of the Physiotherapy Department at the Norfolk and Norwich Hospital, for her teaching and demonstration of the treatment of soft tissue injuries with ice. Her department has been successfully using this form of treatment for some time, and now has had sufficient experience to recommend its use in a large variety of soft tissue and joint injuries.

In the application of this treatment to football injuries, there is the obvious advantage of instant attention when compared with the unavoidable delay before a patient reaches the physiotherapy department.

The principle is not new, for it is well known to all that the football trainer's cure-all is the cold, wet sponge which he carries in his little brown bag. Every first-aider knows how to treat sprains and bruises with cold compresses, which will relieve pain and control swelling, and when ice is used there is every reason to believe that it will do the job so much better, which it does. Local temperatures are quickly lowered, circulation is decreased and haemorrhage—both deep and superficial—is arrested or slowed down. In so doing, any subsequent damage to damaged muscle or joints by the pressure of blood at the site of injury may be prevented.

Spasm, which invariably occurs when a muscle-group is subjected to injury, results from a reflex along afferent nerve fibres returning via the anterior horn cell of the spinal cord along the efferent path to the muscle. This reflex and the spasm resulting from it can be abolished by the slowing down effect of ice on the nerve impulses.

Anaesthesia of the nerve-endings at the site of application is yet another by-product of ice therapy, which allows increasing range of activity in the immediate and subsequent treatment of a damaged limb. Effusion and swelling are more quickly dispersed, probably as the result of the local erythema produced and the ever-increasing range of movement that its anaesthetic properties allow.

It may seem strange that it has taken so long for this simple treatment to receive the recognition that it deserves, but then the introduction of any new type of therapy to the football world is viewed with as much suspicion and distrust as it would be by any doctor.

It is the aim of all those involved in the treatment of the injuries of the professional footballer to restore them to match-fitness in the shortest possible time and when indicated, treatment with ice seems to be the method of choice.

Once the prejudice of those used to the more sophisticated machinery has been overcome, an ever-increasing enthusiasm in this simple form of treatment gathers momentum.

In the initial stages, blocks of ice were obtained and delivered to the ground by the local fishmerchant, who was also a keen supporter, otherwise he would never have put up with police instructions to get his ****! truck out of the way. To reduce large chunks of ice to a suitable size, they were hammered in a folded blanket. The pieces were then put in a bucket and mixed with water to produce a slushy consistency. Rough towels were then soaked in the icy slush, wrung out, and then applied to the injured limb.

These were the instructions that were given, but like the Army, the football world has its own way of doing things. A footballer with a badly sprained ankle, with an estimated recovery time of at least two to three weeks, was seen standing with one foot in a bucket of water. It so happens that he did not get frost-bite, and was fit to play league football three days later. From that time on the ice treatment was accepted with enthusiasm, and recognised as the treatment of choice for most of the soft tissue injuries. Once accepted, the method of application was soon adapted to the needs of the game, and the trainer will now be seen running on to the field with a plastic bag containing icy slush, and a sponge. Sometimes, just a plastic bag containing the ice slush is applied direct to the injury.

It is safe to say that by introducing this new technique haemorrhage is better controlled, and a resultant haematoma limited in size, and in doing so further tissue damage prevented. As well as this, pain is relieved initially, and subsequent application enables follow-up treatment to be carried out with increased range of joint movements.

It has been made clear that in introducing a new type of treatment, full co-operation must be obtained from all concerned. It has been pointed out also, that whilst initiative is desirable, deviation from the method laid down should not be employed until after full consultation. This is demonstrated by the successful treatment of the ankle in a bucket of water, which might have ended in disaster.

It would be churlish not to mention that the success of this treatment is in no small way due to the help of the fish merchant, Mr. E. Valori.

Dr. Woolstone is the Medical Adviser to Norwich City Association Football Club.

The Address at the Memorial Service, 5th April, 1971

for

The Late Professor S. J. de Navasquez

by J. B. Blaikley, C.B.E., F.R.C.S., F.R.C.O.G.

Professor de Navasquez, throughout the 49, nearly 50 years, he was at Guy's, was universally known as "Sigi", an appropriately informal contraction of his full Christian name Sigibert (or Sigiberto). The son of an Italian father with a strong Spanish connection, as is indicated by the name, he came with his parents to England at a very early age, having previously lived in Brazil.

He was only 16 when he came to Guy's to work for his first M.B., and I first met him some three years later in the "Dissecting Room", where he was twelve months ahead of me (he qualified in 1927), but it was not until later, when he had turned to pathology, and I was a Registrar, that I really came to know him.

Even as a student, Sigi stood out a little from his contemporaries, he was always neatly dressed (even dapper), and went along in his own way with several other somewhat unusual characters, all contemporaries of my brother-in-law. Then, and all his life, he never sought, in fact he always avoided, the limelight. A distant great grandfather was Court Chamberlain to Philip IV of Spain, and as a result Sigi was a hereditary "Count" but he never used the title—it did not fit in with his democratic ideas—and he later dropped the prefix "de". As a student he was already very knowledgeable about "Old Masters", and also food and wine, but never to the detriment of his study of medicine, and pathology in particular.

As a Pathologist, Sigi showed himself to have a keen, critical brain, and this was appreciated at Guy's during his first appointment, which was Assistant Pathologist, and Griffiths Demonstrator in the Department of Pathology; during this time he came to work as an Assistant to Professor Nicholson; but his work here at Guy's was broken by the years he spent serving in the R.A.M.C. as a Specialist Pathologist during the second world war. After the war, he returned and was appointed Reader in Pathology in 1946, and in 1949 he succeeded the late Professor G. W. Nicholson as Clinical Microscopist to the Hospital. That great man had soon realised Navasquez's potential, when the latter first had worked with him. So, as a result of this happy partnership, the pupil succeeded the master to the great benefit of Guy's during the ensuing years. It cannot have been easy to succeed Nicholson, for he, in the estimation of those best qualified to know, was one of the two or three most distinguished men in the world this century, in his own field—namely "The Study of Tumours". Both Nicholson and Navasquez were humble men, however, and it is probable that neither was fully appreciated in his life-time. Both were great teachers to those who were interested and sought them

out in their sanctums, and were prepared to listen to what was often not only an erudite, but a somewhat philosophical dissertation on the problem in hand. I knew both well and there was indeed a similarity of outlook.

I think it is true to say that Sigi endeared himself to a host of Guy's men, and numerous others. He was always so unprententious, so detested humbug and arrogance, and was always so ready to enlist another opinion if there was doubt as to the nature of a tumour.

In his daily life Sigi was undemanding, loved simplicity and in fact was basically, anyhow from the time he qualified, an ascetic, though well able, to the end, to enjoy a little food and a little wine with a friend. He had a tranquil, even serene spirit, and bore the buffetings of misfortune with great calmness and fortitude. He, himself, had remarkably good health but his wife unfortunately has suffered serious ill-health ever since soon after they married, but this did not destroy their companionship.

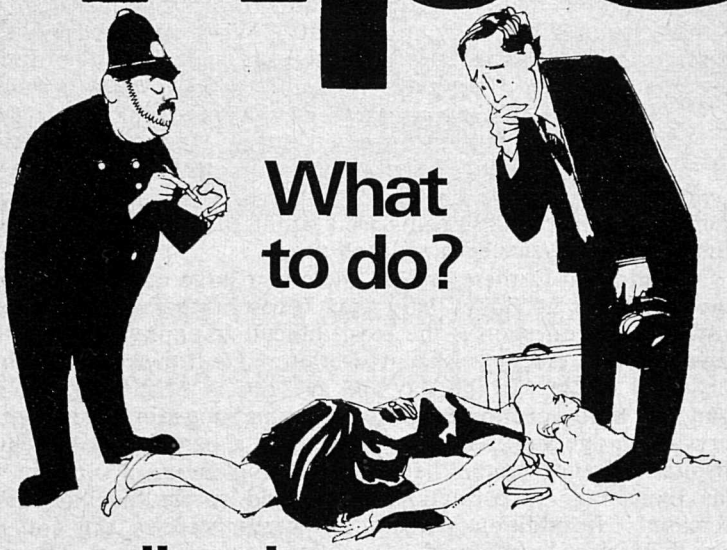
Professor Navasquez's chief delight, outside his work, was in things artistic, and he had a profound knowledge and appreciation of Italian Renaissance Painting in particular, but he also loved anything beautiful in design or shape, whether a building or something made, for example, of silver or glass, and he also loved music, as witness the music we hear today from Verdi's Requiem.

Lastly I must mention his great affection for this country, and his tremendous respect for its achievements. He was a great admirer of British democracy, tolerance, and good sense, and he believed these three would see us through all our troubles. We can only hope that his sanguine optimism will prove well-founded.

This morning we have paid tribute to the memory of an unusually interesting Guy's man, a most devoted Guy's man, and one who, throughout his life, gave most conscientiously of his time and energy both to Guy's and medicine in general. It is sad that his brief retirement should have been clouded by so much illness, but I believe he would have considered himself fortunate to have died so suddenly and peacefully during his sleep from a coronary thrombosis. He had gone to bed early after eating his usual simple evening meal (with a little wine) in the company of his invalid wife.

Today we remember him as we knew him, kind, cheerful, philosophical, always courteous, and at all times humble.

mps



medical protection society est 1892

Unlimited legal aid
and indemnity against
professional hazards
throughout the world
(except U.S.A.)

Secretary Dr. H. A. Constable. Head Office
50 Hallam Street, London, W1N 6DE. Tel: 01-580 9241
or Regional Secretary Dr. P. G. T. Ford
Regional Office: 30 Park Square, Leeds 1. Tel: 0532 42115-6

NURSING SECTION

The Question Why

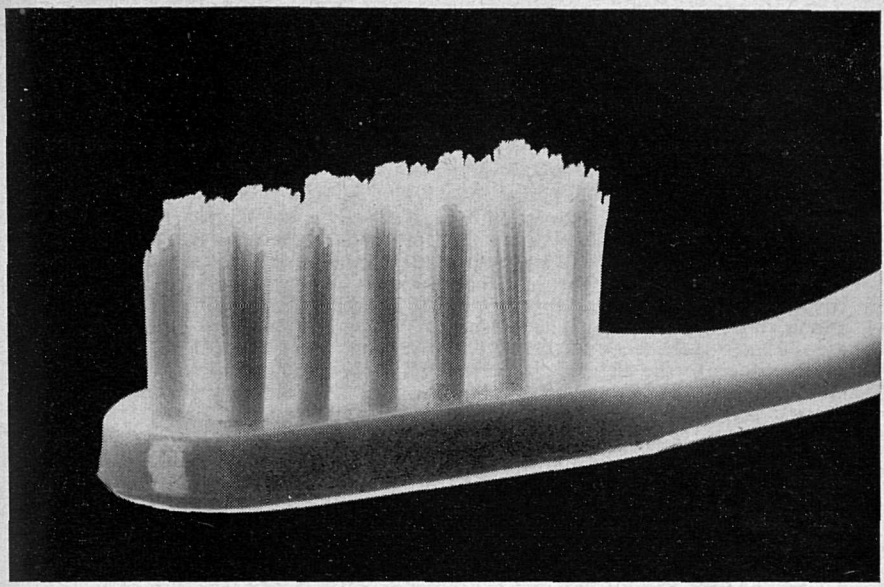
Anyone who elects to pursue nursing as a career, has inevitably, on many occasions, to provide an answer to the question "Why did you choose this?" The reasons, not unnaturally, will vary considerably and it might prove interesting to consider these briefly.

Nursing, of course, in common with other walks of life, is bound to have a considerable number of adherents who are following in the footsteps of their forebears. These then, will constitute quite a sizeable proportion of the numbers in the Profession today and in the future. Another sizeable group are those who have elected to nurse because they feel that the academic requirements are not as demanding as those required for study at university. Whether or not they should be is currently a highly controversial issue and cannot be discussed here. Unfortunately, however, most girls' schools tend to foster the view that the Profession is a respectable occupation although it is not quite what they would wish for their pupils. Many people now nursing will have experienced the patronising attitudes of their headmistresses when announcing their intentions. This is particularly pronounced in the establishments who count their success only by the number of university entrants each year.

In addition to these groups, there is a large collection of people who really do not know why they became nurses. For these, the answer to the question is the most difficult to express. They simply know that they always wished to do this and had their careers planned very early in life. In this day and age, one is a little diffident about using the word vocation but certainly something stimulates them at a very young age and this is not necessarily a period as a patient in a hospital. If, on the other hand, it was the glamour of uniform which was the source of attraction, this would surely fade as maturity increased. In addition, parents, like headmistresses, are not, unless they themselves have a medical training, very enthusiastic about their daughters doing work which, even today, is considered by some to consist of cleaning floors. For doting mothers and fathers, the letters S.R.N. after their daughter's name do not hold the same appeal as B.A. or B.Sc.

For those who wish to nurse then, encouragement is frequently difficult to find. The ones who adopt the idea as children and steadfastly maintain their ideal will have proved their strength of character long before they reach eighteen years of age. Additionally, having acquired their majority, they will be no nearer the answer to the question which they undoubtedly will be asked at their interview. If they give an honest answer, its reception will be a somewhat sceptical look.

Despite all these drawbacks, however, there are, and doubtless will continue to be, a considerable number of nurses in this country who did it purely because they wished to. Throughout their lives, they will have to continue their search for the answer to the question "Why?".



When they say this hurts, Sensodyne builds protection for sensitive teeth.

It's the old story, hypersensitivity means pain and fear of brushing, and this leads to oral neglect.

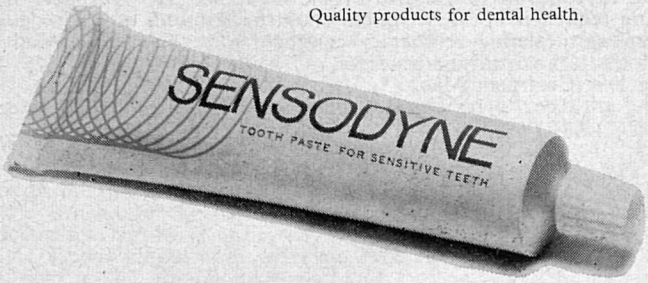
Sensodyne is a toothpaste especially produced for the adjunctive treatment of hypersensitivity. It contains strontium chloride – a therapeutic agent with a cumulative desensitising action.

The more your patient brushes with Sensodyne the less brushing hurts, so the habit of regular brushing is quickly regained.

Sensodyne helps 9 out of 10 sensitivity patients and completely relieves 2 out of 3.

STAFFORD-MILLER

Quality products for dental health.



CORRESPONDENCE

Cot Deaths

SIR,—Mr. Neil Barber has written an interesting account of cot deaths, and with kindly perception has indicated that parents suffer not only grief, but may blame themselves when there is no substantial reason.

Some time ago an interesting proposal was put forward by a visiting lecturer at Oxford that cot deaths were perhaps caused by failures of conduction in heart muscle. He argued that the Bundle of His was a wide pathway in foetal and early infant life that became trimmed down as the heart developed. In particular he claimed that the fibrous skeleton of the mitral and tricuspid rings strangulated some of its conducting tissue. He provided a good deal of evidence to this end from animal and human dissection specimens. Moreover he claimed that arrhythmias preceded death were unlikely to be detected. Not all are cot deaths and there have been instances of the babe dying suddenly perhaps when being nursed.

I hope, at least, that I shall stimulate Mr. Barber to look into this and perhaps to confirm or refute it. Finally I am sure he will know that there are recent claims that a critical degree of congenital narrowing of the larynx may sometimes have an important effect.

Yours etc.

ARTHUR WILLIAMS

85, Banbury Road,
Oxford, OX2 6LG.

"La Spitsia?"

SIR,—I would like to make use of your correspondence column to express my views on the quality of the food served in the Students' Refectory (popularly, but with good reason, known as the Spit).

In all my long experience of eating in similar refectories, I have never been expected to put up with such revolting fare: I have seen canteens at other hospitals which provide much better quality for nearly half the price. It is not, however, the price that concerns me primarily, but the quality. After nearly five years of eating in the Spit, I find that the majority of meals give me no pleasure at all, but are rather an unpleasant chore which I have to perform if I am to survive. The food has a characteristic aroma which I shall remember until my death-bed; I swear that if I were led, blindfold into the Spit, I would recognise where I was by the wave of nausea which its odour excites.

Could I make an impassioned plea to those in high places who are responsible for the Spit to improve the quality of its food, even if that would necessitate a reduction in the size of the menu offered. Perhaps, also with the coming reduction in S.E.T., prices could be reduced, or must the pockets of the capitalist catering aristocracy continue to be lined as a result of the exploitation of impoverished students.

Long live, Chairman Mao!

I beg to remain, sir, your most humble and obedient comrade,

ARNOLD SCHULTZBERGER.

East Wing,
Guy's Hospital.

SPORT

CRICKET

1st XI v. HORSHAM

Away. Sunday, 25th April.

In a fairly typical start to the season, and true to tradition seven Guy's men were in attendance at Horsham (15 minutes late) to begin the first match of the new season. In all, nine turned up and further help came from D. Oram who, happening to be at home in Horsham for the week-end, volunteered his services.

With no regular opening bowler around, that ace speed-merchant A. Gillham was called upon to open the bowling. In true Wes Hall style he proceeded to take 4 for 67 (only one was caught on the boundary!) and with O'Keefe bowling well from the other end, and some reasonably good fielding (apart from some notable gymnastics) Horsham declared, leaving Guy's to score 171 to win in 130 minutes.

With J. Rees out when the score was only 1 the task seemed stiff. But Gillham and Goodhart had a stand of 105, of which Goodhart made an excellent 80. Gillham unfortunately scored very slowly, although he ended up with 38, and his running between the wickets was not as fast as we have seen it!

A possible victory was turned into a scrambled draw as the middle order batsmen were bowled rapidly out, but Langdon and O'Keefe managed to stick it out and with the final score at 138 for 7, Guy's remain unbeaten.

TEAM: Goodhart (Captain), Langdon, Gillham, Clifford, Jones, Rees, Scoble, O'Keefe, Hutton, J. Oram, D. Oram.

Coming matches:

MAY

Saturday, 1st, v. Putney H.O.P. 2.00
Sunday, 2nd, v. London Hospital H.O.P. 11.30
Wednesday, 5th, v. Wanderers H.O.P. 11.30
Saturday, 8th, v. Carnegie H.O.P. 2.00
Sunday, 9th, v. Ashstead Away 2.00

CHRIS LANGDON

GOLF

HOSPITALS CUP—ADDINGTON GOLF CLUB

Wednesday, 24th March.

Semi-final v. Middlesex

Won 3—2.

Final v. London

Won $3\frac{1}{2}$—$1\frac{1}{2}$.

The semi-final and final of the Hospitals' Cup were played at Addington Golf Club on Wednesday, 24th March.

In the morning, Guy's played the Middlesex in the semi-final, while the London, who had already reached the final, warmed up by playing a practice round.

The match versus the Middlesex, was noticeably tense. In the top match, Richard Ibbetson was four down after four holes and wondering if he would be better employed as a spectator, but making a good recovery from three down with four to play, finally lost at the nineteenth. Neil Davies played tediously badly and ended by having an early lunch, while the sick and infirmed Dai Rowley-Jones stunned everyone by overcoming great odds to win 4/3. Meanwhile, Jim MacKenzie, who has an unbeaten record in cup matches, and David Roper played with nerveless skill and great tenacity to bring us into the final in the afternoon.

In the final against the London, Richard Ibbetson, after a good start, putted like a man with no arms and lost by two holes. There is not much to say about Neil Davies except that once again he played very tediously, but this time tediously well and ran out an easy winner by 8/7. Dai Rowley-Jones, donning a very dashing cap especially for the occasion, fought back from four down with eight to play, to halve on the last green by holing a putt of 10 feet. Once again the tail wagged ferociously, Jim MacKenzie maintaining his unbeaten record by winning 3/2, and David Roper firing with the utmost precision, strolled to a 5/4 victory. Thus Guy's retained the Cup for another year due to inspiring exhortations and leadership of Dai Rowley-Jones!

R. J. IBBETSON.

HOCKEY

HOSPITALS CUP FINAL REPLAY
GUY'S v. ST. THOMAS'S

Lost 4—0 at Westminster's Ground.

I regret to have to write that Guy's were comprehensively beaten by a skilful St. Thomas's side in this replay of the Hospital Cup final. Having had a fairly successful season, including the winning of the University college championship, Guy's were anxious to complete the season by beating St. Thomas's outright. Last year the cup was shared with St. Thomas's. The side must sorely regret that they did not take advantage of their domination of play in the previous game several weeks ago.

St. Thomas's fielded a side containing eleven class players—all able to control the ball beautifully and find their passes on the excellent Westminster ground. Their side included three internationals. Guy's, too, had their stars, but the team was not well balanced.

The forwards, in particular, were weak, and many attacks starting from the defence, floundered on the wings. Both wings were 2nd XI players, neither of whom had played for several weeks. One sympathised with them, for they tried hard, but to little avail. It seems a pity that some players did not know they were playing until a very few days before, and thus had no chance to prepare for such an important game.

The two first half goals were created from St. Thomas's left, following a disabling bang on our right-half's knee. The goals were well taken, giving Clark, in goal, very little chance.

One hoped that in the second half some trump might turn up against the odds, but although everyone did their utmost, it wasn't enough—Guy's just had nothing up their sleeves

In defence, D. Crafts played excellently, and both he and Bob Fell were always in the right place, trying to stem the tide and initiate an attack. Amongst the forwards, R. Burn's (captain) example maintained the team's spirit, but only R. Clark was able to support him in terms of skill, and a two-pronged attack inevitably came to grief against St. Thomas's barricade. The nearest we came to scoring was with a series of penalty corners, all ably struck by David Crafts, but each just insufficient to beat the goalkeeper.

Sadly this was probably the farewell match for three of the stalwarts of the club in the last few years—Bob Clark, Mike Velacott and David Crafts. The contribution of all three to the club, both on and off the field, has been immense, and Guy's will be fortunate if they find replacements to match their calibre. For these three and for the large band of spectators it was a disappointing result, but we were beaten by a highly competent side.

B. MARTINDALE.

Team: R. Clark, M. Velacott, D. Crafts, P. Nicol, R. Fell, P. Calvert, G. Sparrow, R. Burns, R. Clark, J. Walker, I. Cooper.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL

Applications are invited for the following **Dental House Surgeon Appointments** for the period 15th July, 1971, to 14th January, 1972.

	Vacancies
General Duties	5
General Duties with Oral Medicine and Pathology	1
General Duties with Oral Surgery	1
Resident (General Duties)	2
Prosthetics Department	1
Children's Department	2

Application forms are obtainable from and should be returned to Mrs. J. M. Webster, Administrative Assistant for Medical Staffing, Counting House, not later than **12th May, 1971.**

Candidates may apply for any of the posts advertised and should indicate their preference. They will not be considered for any post for which they do not apply.

P. J. Helliwell,
Superintendent.

22nd April, 1971.

GUY'S HOSPITAL MEDICAL SCHOOL, S.E.1.

Applications are invited for the post of **Junior Lecturer** in the Department of Anatomy, with duties to commence on 1st August, 1971. Forms of application are obtainable from the Dean and should be returned not later than **21st May, 1971.**

GUY'S HOSPITAL MEDICAL SCHOOL, S.E.1.

Applications are invited from medically qualified graduates for the post of **Lecturer/ Junior Lecturer** in the Department of Pathology, with duties to commence as soon as possible. The holder of the post will be concerned with both Diagnostic and Experimental Histopathology. Initial salary according to qualifications and experience, in the range £2,070—£2,260 *(Junior Lecturer)* and £2,450—£3,926 (Lecturer) per annum, with superannuation. Forms of application may be obtained from the Dean, and should be returned not later than **21st May, 1971.**

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited for the appointment of **Lecturer** (half-time) in the Unit of Anatomy *in Relation to Dentistry with duties commencing* as soon a possible. Salary with the range £795—£1,758 with Superannuation. Forms of application are obtainable from, and should be lodged with The Dean, Guy's Hospital Dental School, London, S.E.1. not later than **31st May, 1971.**

PERSONAL

GROUND FLOOR furnished flat. Three rooms, bathroom, telephone. Brockley, few minutes London Bridge. £8.50 weekly. Rev. R. Frost, telephone 274 5001.

EASTBOURNE—Associateship vacancy in modern expense-sharing dental group practice, full or part-time, minimum three days per week, no capital required, increasing private work. Tel: Abbey Associates Eastbourne 27609.

THREE-MAN entirely private dental practice in Camberley, Surrey, requires assistant aged 25—30 with view to early partnership to replace recently retired senior partner. Experience of crown and bridgework an advantage. Telephone: Camberley 63196.

ACCOMMODATION available in Cavendish Square, London, W.1. Consulting rooms and/or dental surgery available immediately. Box No. 4/4.

BIRTHS

SCHOLEFIELD—On 12th February at Hereford to Judy (née Craven) and Dr. Robert Scholefield, a son, David Bernard.

MITCHINER—To Rosaleen (née Hawkins, S.R.N.) and Michael on 29th March a son, James Patrick, brother for Christopher, Kathleen and Sheila.

LLOYD JONES—On 14th February, 1971 to Rosalie (née Harrison Bloom) and Ken Lloyd Jones, a daughter, Catrin, sister to Huw.

BIGGS—On 7th April, 1971, at Zachary Merton Maternity Hospital, Rustington, to Kate (Née Ramsker) and Derek Biggs, a daughter, Avril Monica, a sister for Jonathon.

MARRIAGE

BURROUGHS—CLYMA—On 26th September, 1970, at *St. John's Methodist Church,* St. Austell, Cornwall, Edward John Carbrooke Burroughs to Elizabeth Ann Clyma.

DEATH

YERBURY—Suddenly on 19th February, Richard "Hank" Yerbury, Q.H.S., C.B.E., M.B.B.S., R.A.F., Guy's 1932-1937.

CHANGES OF ADDRESS

S. J. S. Lam, Esq., F.R.C.S., "Vines Gate", Brasted Chart, Westerham, Kent. Westerham 3608.

Mr. and Mrs. E. J. C. Burroughs, 5, Harworth Place, Bawtry, Doncaster, Yorks.

Major and Mrs. N. J. Knott, c/o Army Dental Centre Larkhill, No. 3 Group R.A.D.C., The Packway, Larkhill, Wilts.

Dr. and Mrs. M. B. Mitchiner, Ravenhill, Rectory Park, Sanderstead, South Croydon, Surrey, CR2 1JR.

Dr. and Mrs. R. M. Lloyd Jones, Sherwood, Kirkby Road, Ravenshead, Nottingham, NG15 9HF.

PAPERS BY GUY'S MEN

Birkett, F. D. H. and Davies, C. J. Safety-pin swallowers. *British Medical Journal*, 1971, **1**, 504.

Camps, F. E. and another. *Practical forensic medicine*. Hutchinson, London, 1971.

Chamberlain, J. H. Tissue respiration. In *Scientific foundations of anaesthesia*, edited by C. Scurr and S. Feldman, p.259. Heinemann, London, 1970.

Cremin, B. J. Congenital pyloric antral membranes in infancy. *Radiology*, 1969, **92**, 509.

Cremin, B. J. and another. The roentgenologic features of haemoperitoneum in the newborn. *American Journal of Roentgenology*, 1969, **106**, 193.

Cremin, B. J. Unusual causes of incarcerated hernias with radiological diagnosis. *South African Medical Journal*, 1969, **43**, 851.

Cremin, B. J. Biliary parasites. *British Journal of Radiology*, 1969, **42**, 506.

Cremin, B. J. Diastrophic dwarfism. *Australasian Radiology*, 1970, **14**, 84.

Cremin, B. J. Polyps in the large bowel in children. *Clinical Radiology*, 1970, **21**, 195.

Cremin, B. J. Familial osteoarthropathy. *British Journal of Radiology*, 1970, **43**, 568..

Cremin, B. J. Racial significance in pyloric stenosis. *South African Medical Journal*, 1970, **44**, 1131.

Dixon, A. St. J. The rheumatoid foot. In *Modern trends in rheumatology*— 2, edited by A. G. S. Hill, p.158. Butterworths, London, 1971.

Fox, C. A. and another. Milk-ejection activity (oxytocin) in peripheral venous blood during lactation and in association with coitus. *Journal of Endocrinology*, 1969, **45**, 145.

Fox, C. A. and another. Blood pressure and respiratory patterns during human coitus. *Journal of Reproduction and Fertility*, 1969, **19**, 405.

Fox, C. A. and other. Measurement of intravaginal and intra-uterine pressures during human coitus by radiotelemetry. *Journal of Reproduction and Fertility*, 1970, **22**, 243.

Fox, C. A. Reduction in the rise of systolic blood pressure during human coitus by the beta-adrenergic blocking agent, propranolol. *Journal of Reproduction and Fertility*, 1970, **22**, 587.

Grahame, R. and others. Treatment of systemic sclerosis with D-penicillamine. *Annals of the Rheumatic Diseases*, 1970, **29**, 153.

Grahame, R. and others. Radioactive colloidal gold in chronic knee perfusions with Baker's cyst formation. *Annals of the Rheumatic Diseases*, 1970, **29**, 159.

Grahame , R. A method for measuring human skin elasticity in vivo with observations on the effects of age, sex and pregnancy. *Clinical Science*, 1970, **39**, 223.

Grahame, R. and others. Clinical survey of 354 patients with gout. *Annals of the Rheumatic Diseases*, 1970, **29**, 461.

Grahame, R. The physical properties of the skin in the Ehlers-Danlos syndrome. In *The Ehlers-Danlos syndrome*, edited by P. Beighton. Heinemann, London, 1970.

Healey, T. E. J., Vickers, M. D. and another. Physiological responses to intravenous diazepam as a sedative for conservative dentistry. *British Medical Journal*, 1970, **3**, 10.

Healey, T. E. J., Vickers, M. D. and others. Interdisciplinary study of diazepam sedation for outpatient dentistry. *British Medical Journal*, 1970, **3**, 13.

Israel, S. and Draper, P. General practitioner hospital beds : a review. *British Medical Journal*, 1971, **1**, 452.

Mikikits, W., Skinner, A., Spector, R. G. and Watts, D. C. Influence of pH on aggregation and protein binding of barbituric acid and amylobarbitone. *British Journal of Pharmacology*, 1971, **41**, 76.

Polani, P. E. and Mutton, D. y-fluorescence of interphase nuclei. *British Medical Journal*, 1971, **1**, 461.

Stafford-Clark, D. Psychiatric emergencies. In *Compendium of Emergencies*, 3*rd edition*, edited by H. Gardiner-Hill, p.151. Butterworths, London, 1971.

Sullivan, F. M. and another, eds. *Carbenoxolone sodium*. Butterworths, London, 1970.

We would like to remind our readers that all copy for inclusion in the "Gazette" must be received eight days before publication date.

Copy may be sent to us c/o The Front Lodge, Guy's Hospital or left in the "Gazette" pigeon-hole in the East Wing.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, please indicate whether or not this should be published.

Personal notices one shilling per word (pre-paid) (minimum £1. 1s. 0d.).

Non-subscribers will pay £1. 1s. 0d. (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

EDITORS N. D. S. BAX and A. M. TURNER
NEWS EDITORS R. M. DARLING and J. L. LEWIS
SPORTS CORRESPONDENT A. M. ROYSTON
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TEN PENCE VOLUME 85 NUMBER 2161

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

The Was Library

Once upon a time the Will's Library was undoubtedly a good library with ample comfortable seating, up-to-date books and a quiet atmosphere. Sadly, all these are now absent and as has been mentioned in a previous Passim, the Will's library is rapidly becoming a second Spit. People now read their newspapers there and some have been seen knitting.

Increasingly more people wish to use the library for its original function but are becoming more frustrated. Whenever one wants a book it means disturbing many others even to the extent of their sustaining head injuries when a cupboard door is opened. More important, though, the books available are on the whole old ones and in many instances completely out of date. Little seems to be being done to replace these books with modern works of reference.

One guaranteed manic engendering device available to all is playing "hunt the journal game". The number of times one is unable to find the particular issue for which one is looking is too many. Indeed, some of the journals taken are most incredibly obscure, whilst many perhaps more important ones could be taken instead.

Imagining, though, one has found the desired book or journal, and a seat that is not broken or has entertained somebody else's feet, and a table that does not tip up, one more often than not has to contend with the noise of duplicating machines, aeroplanes, lawn mowers and an amazingly high basal level of noise. A situation less amenable to study could not be imagined.

Obviously the time has come, in truth is well past, when a complete rearrangement of the library facilities at Guy's is essential. One can only hope that the restocking of books, maintenance of the journal complement, the repair and replacement of the broken furniture and attempts to reduce the noise level will be treated as a matter of priority.

Lock up your children

The evils we fear are those beyond our reach. A fearsome challenge to all communities, and particularly to this one of supposed reason, is a person who is ignorant of the customary traditions of behaviour, one who is incompetent in the intricacies of communication of the rest of us. Such a person is weird to us, and scaring because we generally feel that there is no way the ordinary person can build a happy relationship with the mentally subnormal or otherwise handicapped. Parents of such children sometimes feel a natural revulsion for the child, natural in this context meaning that many people experience the feeling. They often feel the child would thrive better in a large building full of other such people, deprived of the love and personal attention given by the family and regarded as so essential to a child's full maturity. The resolution of the fear and diffidence about ability to cope consists in removing the *problem* from our sight; putting it beyond our reach.

Clearly we must solve the difficulties of the child and the family at the same time. The argument that the revulsion or feeling of inadequacy exists therefore must be right withstands little criticism, and should not be indulged. Not only are mentally sub-normal children entitled to as much of our care as anyone else, but we also gain in our lives from living with the less independent; from contact with those who can give us less economic return but pure kindness and friendship; from realising the vanity of most human wishes. The Secretary for Social Services, in considering the case for integrating mentally subnormal and handicapped people into the community, should well remember that the present separation is of little value to the handicapped and reveals the meagre tolerance and myopia of the rest of us.

GUY'S DIARY

MAY

25	Tu	1.00	Clinical Lecture. Dr. MANN. "Fever."
27	Th	1.00	Clinical Lecture. Dr. HELLIWELL.

JUNE

4	F	2.15	Combined Round. Dr. SOWTON and his firm. "Assessment of Surgical Treatment for Angina." Chairman: Dr. H. KEEN.

NEWS IN BRIEF

George Puzinowski

It is with great sadness that we announce the death of George Puzinowski, who was a first year Clinical Dental student, aged 20. He was fatally injured in a motor-cycle accident outside Swindon on 1st May, whilst travelling down to see his parents at Cirencester; no other persons were involved.

About 25 of his closest friends from Guy's attended his funeral, which was held at the Roman Catholic Church of St. Mary's, Cirencester.

Our deepest sympathies go to George's parents, who so tragically lost their eldest son and to all his friends who will never forget what a likeable, warm-hearted person he was.

George's parents extend their gratitude to everyone who contributed towards his wreaths.

Name Labels for Patients

Until recently, at Guy's, the investigation of a patient meant filling in several forms by housemen or students. The old system included at least twelve different forms, most of which involved carbon copies. Such was the pressure of work that details about the patient were either omitted or inaccurate. Sometimes the laboratory did not know where to send results simply because the patient's ward had been omitted from the form. Also the copies of the request form—kept by the laboratories—were often too faint to be read. It was for these reasons that gummed labels, containing enough information for the identification of each patient, were introduced.

When a new patient is registered or any patient admitted, his name, age and hospital number are typed on to an aluminium foil plate, from which twenty labels are printed in a few seconds. Both the plate and the labels are left in the patient's notes.

Request forms have been reduced in number and redesigned to accommodate these labels and eliminate the need for carbon copies. Results are now photo-copied in the laboratories and the copies returned to the wards for filing.

The name-label system has been introduced to the Guy's group at a cost of £8,200 for five years. This includes four printing machines (two at Guy's, one each at St. Olave's and New Cross) and special typewriters for making the aluminium plates. In addition, each sheet of 20 labels costs 1p. Four part-time staff have been employed to operate this system, which should be in full use by the end of June.

New Chief Nursing Officer

Miss Eileen Haigh, S.R.N., S.C.M., has been appointed Chief Nursing Officer: she will start here early in September. After training at the Radcliffe Infirmary, Oxford, Miss Haigh was later Matron of Queen Mary's Hospital, Roehampton, part of the Westminster Teaching Group. She is at present Matron of the Canterbury District General Hospital (including the Kent and Canterbury Hospital).

We would like to welcome her, and hope that she enjoys her time at Guy's.

Professor of Medicine

Dr. Maurice Lessof has been appointed to the Chair of Medicine, to succeed Professor Butterfield. Dr. Lessof qualified at Guy's in 1947, attained the M.R.C.P. in 1949, and M.D. in 1956. From 1955-56 he was Registrar in the Endocrinology Department under Dr. P. M. F. Bishop, and he has also spent some time at the Johns Hopkins Hospital, Baltimore, U.S.A. After working as Senior Lecturer in the Department of Medicine, he was appointed Consultant Physician at Guy's in 1967. His particular interests are endocrinology and clinical immunology.

St. Olave's Medical Firm

This April, a new medical firm was started at St. Olave's, under Dr. Maclean. Dr. Abrams, Dr. Clark, Dr. Cox and Dr. Grahame provide additional teaching and a good selection of patients. The large number of patients available both from routine admissions and take-in makes the choice of patients for clerking and student care selective rather than routine.

The teaching is varied and of a high standard and is supplemented by postgraduate meetings and case conferences. The size of the hospital confers the additional benefit of making other departments more accessible and the ready availability of Dr. Fullerton of the Pathology Department, and Dr. Hoskins of the Radiology Department offers valuable supplementary teaching. The further advantage of assisting the houseman with blood-taking rather than having full responsibility for all such investigations, allows more time for worthwhile educational pursuits. No longer need rounds be missed for the sake of a G.T.T.

There must be few hospitals with two magnificent tennis courts and even fewer where the students take-in accommodation is envied by the doctors.

The informal atmosphere encourages a greater feeling of participation in patient care and those senior students who are prepared to live-in for a period are offered the opportunity to act as assistant house physicians. This makes St. Olave's an important addition to the choice of medical firms.

Paternity Testing at Guy's

I. D. Bradbrook

It was in 1900 that Landsteiner discovered that the serum from one individual might agglutinate the red cells of another individual. He was therefore able to classify humans according to their specific agglutination reactions, which were later designated the ABO groups. The mode of inheritance of these ABO factors was not elucidated until twenty years later, when Bernstein (1924) showed that the factors were controlled by genes that obey the laws of Mendelian inheritance. Since this initial discovery a large number of other factors (antigens) present on the surface of human red cells have been demonstrated. The Central European and Scandinavian countries were the first to use these blood group properties in legal cases of disputed paternity. The first reported use in the British Isles appears to be in the Dublin Circuit Court in 1932, and the first English case, an ABO exclusion in a paternity case that appeared before the Workington magistrates, in 1938.

The purpose of blood grouping in matters of disputed paternity is to provide the court with useful additional information as to whether the alleged father is or is not the actual father. The evidence given by the serologist does not prevent the court from reaching a verdict that is not in accordance with his findings. The most famous case in which this occurred, was Berry v. Chaplin. In this case blood group evidence showed that Chaplin could not be the father of the child in question, but the California Supreme Court found in favour of the mother.

Scientific evidence is fallible and therefore must be of the highest standard possible. The serologist must be an expert in blood grouping techniques and blood group genetics, and his procedure should be performed with minimum risk of an error occurring. His report can then be given its proper credence when it is assessed alongside the other evidence.

As previously stated, the use of blood group genetics in paternity cases is dependent on the Mendelian laws of inheritance. For each individual system, e.g. ABO, Rh, etc., an individual's blood group is the result of two factors determined by the blood group genes, one of which is inherited from each parent. If a child possesses a factor that neither the mother nor the alleged father can contribute, then assuming maternity, the alleged father is excluded from paternity. Maternity is assumed as there is no advantage to be gained by the mother allowing another woman to impersonate her. This type of exclusion is termed a first order exclusion. The only doubt that could arise in such an exclusion, apart from grouping the wrong samples, or an error in actual grouping technique, is the occurrence of a mutation, which gives rise to a factor present in neither the mother nor the alleged father. The probability of a mutation taking place in the

blood group genes has not been calculated, but the mutation rate for the disease haemophilia has been estimated as 1 in 50,000 approximately. An exclusion involving a single blood group factor being the result of a mutation is extremely small, whilst that with two or more factors almost beyond possibility. The English courts have now accepted that the occurrence of a mutation is so highly improbable that they will not accept it as an argument for the defence.

One of the most important features of blood grouping in paternity cases is the need for the utmost caution to ensure that the correct samples are examined. Attendance by the parties at the laboratory performing the tests is the ideal situation. The mother can then identify the man she alleges is the father of her child. If they attend at different times, then it is essential that the parties are correctly identified. A photograph of the mother, child and alleged father is taken when blood samples are taken at Guy's. If the parties are unable to attend Guy's to have their samples taken, then it is encumbent on the doctor taking the samples to see that they are from the correct persons and that the containers are properly labelled for there is no way, short of retesting fresh samples, in which the serologist or courts can recognise or rectify such faults at a later date. It is essential that these samples are grouped as soon as possible so that spurious results do not occur. If an exclusion is shown, then fresh suspensions are tested using different batches of antisera. It is always open to either of the parties to request a further examination by another serologist.

The other class of exclusion involves the absence of a factor in the child that the alleged father must give. If the alleged man is homozygous for a pair of allelic genes then any of his offspring must receive one of these alleles. The absence of this gene product in the child means that the alleged man cannot be the father. Care must be taken with this class of exclusion as there may be a rare third allele. This allele may be more commonly found in other populations so that it is useful to know the ethnic origin of the mother and the alleged father, and to take steps to test for the rarer alleles.

Henningson has summarised the information that may be obtained from blood group examination in cases of disputed paternity as follows:—

1. The paternity of the alleged father cannot be excluded and the blood group results yield information neither for nor against his paternity.
2. The paternity of the alleged father is found to be incompatible with the principles of the heredity of one or more blood group systems, i.e., a paternity exclusion, which, however, may be of varying reliability according to the system and the exclusion type in question.
3. The paternity of the alleged father is not excluded and the blood group results corroborate the assumption of his paternity to a greater or lesser degree.

4. The paternity of the alleged father is not excluded but the blood group results corroborate the assumption of non-paternity to a greater or lesser degree.

Blood group results can only disprove paternity, never prove it, but in a number of cases it may be possible to provide further information. Occasionally a rare factor or a number of uncommon factors are present in the child's blood that could have been given by the alleged father. With the increasing number of blood group systems being employed it is possible to calculate the percentage of men in the population that could be the father. This figure is dependent on the population being homogeneous.

The percentage of non-fathers excluded by blood grouping tests is dependent on the number of blood group systems used, and the gene frequencies in the community. Which systems are used is dependent on a number of factors :—

1. The genetics of the system are known and no exceptions to the Mendelian laws of inheritance observed.
2. The grouping of the factors within the system gives unequivocal results.
3. The availability of suitable specific antisera.
4. The relative gene frequencies are large enough to expect a reasonable variation of factors.

This last requirement is concerned with routine testing. In cases where an additional exclusion would be useful, or in a case involving two alleged fathers where no exclusion has been found on preliminary testing, then all the blood group systems that can be tested would have to be examined.

Apart from the antigenic factors present on the surface of the red cells a number of serum proteins can be grouped. With the development of more sophisticated techniques in analytical chemistry it is possible to investigate these proteins to see if they show polymorphism. Examples of serum groups that exhibit polymorphism are the immunoglobulins (Gm and Inv groups), the lipoproteins (Ag and Lp systems) and the alpha globulins (haptoglobins and group specific components Gc). The genetics of these serum polymorphisms have been thoroughly investigated and are now used routinely in paternity cases.

The newest group of substances that have been shown to exhibit genetic polymorphism are the enzymes. Phosphoglucomutase and adenylate kinase are at present being typed at Guy's and research into the possibility of using red cell acid phosphatase is in progress. Table 1 shows the systems at present being grouped at Guy's. The exclusion probabilities for each system have been calculated from the gene frequencies observed in England and Wales. The total exclusion probability for non-fathers can be increased further by the addition of new systems. However, it is highly unlikely that the situation of 100 per cent exclusion probability will occur, as this would also mean that paternity could be proved and that every

individual could be shown to have a unique combination of blood groups. This latter is probably true but will be difficult to demonstrate.

Table 1.

Chances of excluding a falsely alleged man using various blood group systems.

System	Exclusion by each system	Total after correction for coincidental exclusions
ABO	0.1760	0.1760
Rhesus	0.2800	0.4067
MNSs	0.3205	0.5968
Kell	0.0334	0.6108
Duffy	0.0481	0.6295
Haptoglobins	0.1807	0.6965
Gc's	0.1586	0.7446
Phosphoglucomutase	0.1532	0.7837
Gm^a	0.0647	0.7971
Ag	0.1446	0.8264
Lutheran	0.0333	0.8321
Kidd	0.0286	0.8360
Adenylate kinase	0.0420	0.8429

References :

(1) Landsteiner, K. Zur Kenntnis der antifermentativen, lytischen und agglutinierenden Wirkungen des Blutserums und der Lymphe. *Zbl. Bakt.* **27**, 357 (1901).

(2) Bernstein, F. Ergebnisse einer biostatistischen zusammenfassenden Betrachtung uber die erbichen Blutstrukturen des Menschen. *Klin. Wschr.* **3**, 1495 (1924).

(3) Henningsen, K. Some aspects of blood grouping in cases of disputed paternity in Denmark. *Methods of Forensic Science.* Ed. by Frank Lundquist, Vol. 2. London and New York. Interscience.

APOLOGY

Mr. Blaikley

We would like to apologise to Mr. Blaikley for stating in a recent issue that he attained the F.R.C.S. in 1941, when in fact it was in 1931.

Mr. Blaikley has also pointed out to us that the term "Medical Superintendent" of Guy's is incorrect—the correct title is just "Superintendent".

May Concert - Review

On the evening of Tuesday, 11th May, a very high proportion of the hospital population missed a very interesting musical evening. When more than three months' work has gone into producing a concert and less than forty people attend the event, one seeks for an explanation.

Firstly, was the advertising adequate? Secondly, did the fact that the concert was to be held in the chapel worry that section of the community to whom "religion" in any form is anathema? These people need not have feared, since by no means all the programme was of religious music. Furthermore, there is nothing either "religious" or "irreligious" about music in itself, and one should not be prejudiced against a piece of vocal music because one happens to disagree with the sentiments that its words express.

Finally, there is the possibility that there would have been a better audience in the open air. It was, after all, a beautiful spring evening !

There were two choirs taking part, the first, conducted by Richard Hayward opening the programme with three short pieces. The first of these, "Rejoice in the Lord Alway," by Redford, opened at a good speed which flagged a little in the middle of the work. The choir had some poor entries here, but in the final slow section came over very well with some pleasantly controlled tenor singing.

Britten's "Hymn to the Virgin" followed, sung with conviction and firm choir entries. The solo quartet was well balanced and sang with feeling throughout, but the performance was marred by inflexible timing, and the conductor's decision to take the "piu mosso" third verse half as fast again as the preceding two. The result was the loss of all the poignancy and beauty of this very moving final verse.

Choir and conductor redeemed themselves, however, with a well-thought-out performance of "Brother James' Air." The lower parts were well controlled in their wordless accompaniment to one verse, and the dynamic range of this choir could be appreciated. Some of the parts tended to run away with themselves in places, and stricter time-keeping would have added the final touches here.

There followed the second appearance at Guy's of Veronique Gregory and Neil McLeod to sing folk songs. The pair are well-matched vocally, and if they were not always fully in tune with each other, this is a fault that will disappear with further work together. They have no cause to lack confidence, and their performance would be improved by more of it. They were joined later in the concert by Wayne Moran, whose guitar accompaniment and voice added useful weight to the sound the group were making.

Paul Gartell and Alison Fookes produced an interesting rendering of "Dolly" for piano and four hands by Fauré. One felt that this item may have been in the nature of light relief, but even so, the

combination of a mechanically unsound piano, and the performers' lack of familiarity with this particular instrument resulted in a performance far from perfect.

The Rhys Williams choir were next on the scene with ten singers and three short pieces. This choir is very impressive in its technical ability despite (or because of?) its small size, and Mr. Williams has clearly put a lot of detailed work into their training. "Steal Away" started with a firm pianissimo, continued with some vocal acrobatics from the altos, and ended with the sopranos showing their ability to reach high notes with apparent ease. A lighter touch in fast passages and greater accuracy in harmony would have perfected this piece. "I Got a Robe" was sung in true Black-and-White Minstrel style, by the basses in particular. "All in the April Evening" could easily have become sentimental, but was prevented from doing so by good control of tempo, and emphasis on the individual parts at the right times.

The concert ended with the return of Richard Haywards' choir with two modern works: "O Lorde, the Maker of all Thinge," by Joubert, and "O Praise God in His Holiness," by Wills. Mr. Hayward must be given credit for attempting these works, since modern choral music requires much more attention to detail to ensure success than does classical music (contrary to popular belief!). It was a brave attempt and there were certainly some very impressive moments and some vigorous singing.

Overall, the concert turned out to be 75 minutes of very competent music-making. I hope that all those who missed it will soon have the opportunity to hear more !

I.D.S.

B.D.A. ANNUAL CONGRESS, EASTBOURNE

Guy's Alumni Luncheon

This will take place in the Mansion Hotel, Eastbourne

on

Wednesday, 9th June,

at

12.45 for 1.00 p.m.

The Mansion Hotel is about five minutes' walk along the front from the Conference Centre.

The cost of the Luncheon will be £1.

Bookings, with payment in advance, please, to—

Mr. James N. Gray, 16, College Road, Eastbourne.

OBITUARY

The Reverend Frederick Nicklin Doubleday F.D.S., M.R.C.S., L.R.C.P.

On 14th April, Palm Sunday, the Reverend Frederick Nicklin Doubleday died after having suffered some weeks previously a severe stroke.

F. N. Doubleday was born in 1885 at Dorking and following a private education completed at Birkbeck College, entered Guy's Hospital Dental School in 1905, thus beginning his long association with the School and Hospital. He qualified L.D.S., R.C.S. Eng. in 1908 and after a period as a house surgeon was awarded the Guy's Hospital Dental Travelling Scholarship which enabled him to study for a year at the University of Berlin. In 1910 he returned to Guy's as a medical student, qualifying M.R.C.S., L.R.C.P. in 1912.

During his more than 60 years' close association with Guy's he was a Demonstrator in the Conservation room, in charge of the Revision Classes, and, at different times, lecturer in Dental Anatomy, Histology, Pharmacology, Dental Surgery and operative Dental Surgery. In 1919 he was appointed assistant Dental Surgeon. He retired from clinical and teaching duties in 1945 and in 1947 was elected F.D.S. without examination. During the First World War he was Dental Surgeon to King George V Hospital, where his special responsibility was treatment of gun-shot wounds of the jaws.

As a teacher, Doubleday enjoyed a high reputation; his preparation of lectures was meticulous and his presentation impeccable. In the Clinics he had the enviable gift of inspiring the greatest confidence in his patients. He was an early user of analgesia; in 1910 he introduced the direct method of injection for mandibular regional anaesthesia and in 1912 advocated the use of local analgesic for conservative dentistry. In the 1920's he observed the marked acid reaction of silicate cements, predating by many years the more detailed work of E. B. Manley and others.

Periodontology was another of his clinical interests; he believed that fuso-spirochaetal infections gave rise to a distinct form of chronic inflammatory response that is specially associated with smoking and best treated with oxygen liberating agents.

Throughout his professional life Doubleday's address was 48 Welbeck Street, where he built up an extensive consultant and general practice. Dental Practitioners from a wide area referred patients to him and many had reason to be grateful for his support and advice in the management of difficult cases. Over the years, many old Guy's men joined him in his practice as assistants and will remember with amusement some of the incidents which took place. An example was the Tuesday afternoon ritual with a barrel organ player who stopped outside No. 48 to give his offering. With the first notes, Doubleday would dash out in fierce remonstration. Honour would soon be settled, Doubleday returning to his patient and the organ-grinder finishing his tune until the next week when the whole performance would be repeated.

In his earlier years, Doubleday travelled widely and lectured extensively, visiting Canada, U.S.A., Holland and Egypt where, at Cairo University, he was visiting professor. His honorary memberships included the Stomatological Society of Greece, and the Stomatological Society of Piedmont.

He was external examiner at Bristol University and examiner for the L.D.S. R.C.S.

During the 1914-1918 war he edited the *British Dental Journal* and was largely responsible for the translations and productions which appeared in the War Supplement. He became an Honorary Life Member of the British Dental Association in 1959. The Royal Society of Medicine held a place near Doubleday's heart and for twenty years he was the Odontological Section Editorial Representative. In 1948 he gave the C. E. Wallis Lecture and in 1949 was elected President of the Odontological Section. Honorary life membership of the Section was conferred upon him in 1956.

Before his retirement, Doubleday returned to Dorking where he bought "Woodcote", in Coldharbour Lane, a house which as a boy, with its exquisite views over the Nower, Ranmore and Leith Hill, he had dreamed would be his perfect home. He became a lay reader in the Anglican Church, but soon he was attending classes at King's College, London, and in the late 1940's was ordained to the priesthood. Prior to becoming the Vicar, he served as Assistant Curate at St. Martin's Church, Dorking. During this time he worked tremendously hard in his new calling and in a comparatively short space of time built up good regular congregations and encouraged a splendid choir of both boys and girls. When full-time parish work became too much of a burden he retired once more but always remained ready to help his fellow clergy in the Guildford Diocese.

As well as his full and busy life as a priest, he managed to find time to edit the "New Rambler"—the Journal of the Johnson Society —and take an active part in the activities of the Shelley-Keats Society. His special interest in Keats arose from the poet's association with Guy's Hospital as a medical student; he also contributed to the still unresolved controversy of whether Guy's or St. Thomas's had the greater right to the claim that Keats was an ex-student.

Doubleday's interest and affection for Guy's remained unchanged throughout his sixty-six years' association. He was a regular visitor and always insisted upon signing the Consultants' book on each occasion. His last visit was on a cold January day earlier this year when, against all sound medical reason, he insisted on attending the memorial service of his old student, the late Professor Martin Rushton.

F. N. Doubelday married in 1908, Jane Barrow-Clough, daughter of a distinguished Methodist Minister of that time. They celebrated their Diamond Wedding Anniversary recently and the number of relatives and friends who came to see them and sent greetings from all parts of the country was a great source of pleasure to them. Jane Doubleday survives him and to her is extended the sympathy of many generations of old Guy's men from all parts of the world.

J.W.M.
M.N.N.

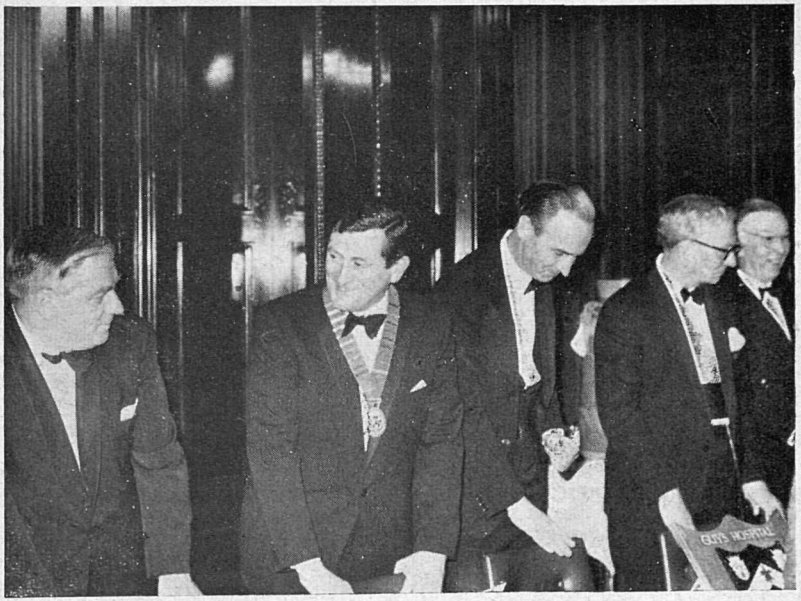
GUY'S HOSPITAL SOCIETY

South Wales

Under the Presidency of Mr. Graham Leighton Davies, R.D., F.R.C.S., The Twentieth Annual Dinner of the Society was held at the Park Hotel, Cardiff, on Saturday, 13th March, 1971, following the Wales v. Ireland Rugby Union International Match.

After the ceremonies of introduction had been completed, Dr. G. A. K. Missen presented an excellent report, illustrated with slides, describing the present and future developments at Guy's. Professor W. J. Tulley delivered an admirable address interspersed with Welsh humour. Following this, Mr. G. Morwent Brown presented to him a cheque for £300 donated by members, including Life Members, to be utilised by the Dean and the School Council, as the basis for a biennial prize to the best student of the year. The prize is to be dedicated to the memory of the late Dean, Mr. Thomas James Evans, M.A.

Both guest speakers were like guns—clean, polished and slightly oiled; and they, with other members of the staff of Guy's, were given a welcome, warmer and wider than anyone could have anticipated, particularly in view of the postal strike. The President presented Society ties to the guest speakers, after they had accepted the higher privilege of being elected Life Members.



From the left: **Professor W. J. Tulley, Mr. Graham Davies, Dr. G. A. K. Missen, Mr. G. Morwent Brown.**

After five years of mourning, the Society's milk churn was once more draped in bright hospital colours, symbolising the delight of all, that Guy's had won the 1971 Hospitals' Cup Final.

It was Salve! Salve! to the Guy's XV and to Dr. Hugh Burry for the magnificent rôle he had played. As a sequel to pressure put upon him, Dr. Hugh Burry proceeded to give a short speech which showed his characteristic frankness, honesty and sincerity. His words were so suitable for the occasion that they will be long remembered by all present.

The "frost of custom" is not allowed to make this function cold and lifeless. There are those, the elders, who recall the past by plunging into poetry, others who sing in unison and in a menacing formation with words to the effect that Guy's patients never die—but that they only fade away!

Success of the Society is primarily due to the fact that it is—"Utrique Fidelis"—faithful to all, young and old, dentals and medicals. The expense of the whole undertaking was large, but the result was highly gratifying to all, particularly to the committee and its officers. Mr. G. Morwent Brown's imperturbability, allied with his continuing advice and enthusiasm over the years, is completely incomparable.

To any Guy's man, this annual function is well worth a visit. *To all Guy's men*—BE SURE to attend our Society's 21st Annual Dinner, following the Wales v. France International at Cardiff in 1972.

D.G.H.D.

BOOK REVIEW

PHYSIOTHERAPY IN SOME SURGICAL CONDITIONS.

Joan E. Cash, B.A., F.C.S.P., Dip. T.P. Faber and Faber, 460 pp. illust. 4th Ed., 1971. £2.25.

This is one of the few books written for physiotherapists and, with its companion volume on Medical Conditions, has been required reading for students since it was first published in 1955.

More than a third of the book is concerned with the treatment of fractures, dislocations and soft-tissue injuries, and there are lengthy sections on Abdominal and Thoracic Surgery, on surgical neurology and peripheral nerve lesions. Each section starts with an account of the relevant anatomy and refers to investigations which may be carried out, before briefly explaining the symptoms and the measures taken to relieve them. The physiotherapy treatment is then given in some detail.

Originally the book was almost entirely Miss Cash's work, but now there are a number of contributions from physiotherapists specialising in different fields. This edition shows some major changes, notably in the chapters on amputations and on surgery of the heart and pericardium which have been completely revised. Elsewhere the text has been brought up-to-date, and the book consequently concerns itself to a commendable extent with modern practice.

It is certain to remain on the physiotherapist's book-list, and it may also be of interest to those concerned with the use of physiotherapy for their patients.

Non Nobis Domine

The comments in this article are of a general nature. They refer to no particular hospital.

Very early in her career, a nurse will no doubt receive her first gift from a patient. Frequently this consists of an orange or apple or small box of chocolates. However, as she grows more senior she will discover that she is asked to accept presents for use in the ward or for her nurses. It seems that even in this day and age, of a grossly deficient Health Service, patients are frequently actually grateful for what they have received!

The attitude in nursing towards gifts has always been a trifle bizarre. In addition, the situation when compared with that of the Medical Staff, presents a complete anomaly. Of course, those nurses working outside the hospitals have no problem, but those within have.

If a patient feels moved to present his doctor with a Rolls-Royce, all the formality required is for grateful thanks to be expressed, and for the jubilant medical man to drive away. If, however, this gift were made to a ward sister she would be expected to report this to her Senior Colleagues, only to be told she could not receive it. This is also true in the case of gifts of money. These presents are supposed to be handed in, an obvious relic of the Voluntary Hospital System. The irony of this is that the money will never be seen again and will be absorbed into the hospital funds. Why should this situation be allowed to continue?

A great deal of time is spent nowadays describing the heavy responsibilities carried by a Ward Sister. If she is thus capable of caring for the sick, why is she considered incompetent to handle any gift which she might be given? How can nurses expect to be thought of as a Profession when the authorities treat their colleagues like errant teenagers?

The astute nurse, of course, soon masters the act of discretion. In addition the patients have now grown wise to this attitude and have learned to circumnavigate. Why, however, should this be necessary? If a patient offers a Sister some money to buy an article for her ward, why should she not be allowed to accept graciously?

In fairness to the authorities, of course, one must state that it is just possible that they may be genuinely concerned about large amounts of money being in the wards and thus becoming a security risk. If this is the case, why do they not allow Sisters to keep it in the Hosiptal safe, but to have access to it when they wish to use it?

Nurses do not get paid fees to look after their patients. They are, however, practitioners in their own right. Why then are they treated this way when their medical colleagues are not? Why should they have to cause embarrassment to patients by saying that they are unable to accept?

What is not appreciated is that this attitude of authoritarianism is immature in its concept and only instigates subversive attitudes on the part of Ward Staffs. Surely this is wrong; if a person is treated as an adult he frequently behaves as one. However, if these archaic repressions continue, the nursing profession is never going to grow up and be thought of as a group of responsible people.

CORRESPONDENCE

Miss Florence Taylor

SIR,—I know that Guy's nurses in many parts of the world will be as deeply grieved as I was to learn that Miss Florence Taylor passed peacefully to her rest on the 23rd April, but how thankful we should be that after her active life of service to her beloved hospital, her students, and to members of the Guy's Hospital Nurses' League, she was spared further suffering and a life of invalidism which she would have found so difficult to bear.

Dear "Sister Flo" what an inspiration she was to us all, and how much we owe to her for her example and for her help and consideration of our problems.

Those who served with her when evacuated to Farnborough Hospital during the years of the last war, will remember her spirit of gaiety and resolution under very difficult circumstances, and in particular, her hair-raising drives—often through the "red lights"—as she rocketed backwards and forwards to her beloved Guy's.

Although she will be greatly missed by her many friends, we must thank God that she is now at rest in His safe keeping.

Yours faithfully,

JEAN RICKNELL (née Addison.)

Chantry Green House,
Steyning, Sussex.

Boxing Injuries

SIR,—I was surprised to learn from the article "Advance in the treatment of Professional Football injuries", that the use of ice in the treatment of damaged soft tissues is only just becoming recognised.

In professional boxing, the ice bag is part of the equipment required by a second before he goes into the corner with his boxer, under the rules of the governing body. The use of ice has been normal procedure for at least forty years.

One notices that in soccer and rugby, the "magic sponge" is still used to cure all manner of ills with varying success.

Those who watched the Cup Final will have noticed a trainer throw water all over a player who had received a bloody nose. This was very spectacular, as it was probably meant to be, but highly inefficient. The use of 1/1000 adrenalin, plus icebag, would have done the job effectively with less discomfort to the player.

A thermos or vacuum flask is a very useful container for ice cubes, and is easily carried around without inconvenience.

Yours faithfully,

W. M. SHEERAN.

262, Portland Road,
London, S.E.25.

Pathology Teaching

SIR,—So Guy's makes its mark yet again by the now almost inevitable honour of being bottom of the University pathology league as regards examination results. This time we wallow deeper into the mire with a miserable 43 per cent. pass rate in the spring pathology M.B. An all time low? More serious though is the rumour that Guy's is rapidly descending into this position as regards all the final M.B. subjects, but I haven't sufficient figures to comment on this.

The pathology results should lead all the worried 57 per cent. and those charged with their education to two questions: "Why?" and "What can be done to avoid this appalling academic spectacle occurring yet again?"

As to why, the fundamental trouble is of course one of the worst student: teacher and patient ratios of any British medical school allowing insufficient staff for individual help or academic guidance. But this is a problem for Margaret Thatcher and not within the scope of Guy's to correct. So we turn to factors which must only serve to exacerbate this already difficult situation.

First to mind is the rigid firm system with its disregard of examinations and formal "all change" every 13th Tuesday. The very names assigned to medical undergraduates—ward clerks or that awful term "dresser" epitomise the apprentice like "walking the wards" method held so dear by our seniors as the only valid way of teaching medicine. The ridiculousness is highlighted by attempting to pursue a course in psychiatry while taking examinations in obstetrics and pathology. A release of final year students from formal firms is urgently called for. Instead a system of clinical revision courses on the wards with four-week periods prior to each examination given over entirely to tutorials is needed, thus relieving the student of irrelevant chores and duties. Student locums should also be encouraged in this final year.

Pathology as a science will never be satisfactorily taught in a framework of rigid firms which always have priority. What is required is either academic courses alternating with clinical courses (the three-month pathology firm idea has been suggested, but could not solve firm-examination clashes), or better, the two running concurrently with the proviso that the former always takes priority. It is this fact, or its disregard, which ruins the present attempt to run morning lectures. This results from two misconceptions by firms of a student's rôle:—

(1) The rigid insistence that all patients be clerked for The Boss's round. This priority forgets the end for which we are here, viz.:—the achievement of clinical skills on a scientific basis, and therefore it is not meaningful for final year students, where history taking should be aimed far more at how to approach difficult clinical problems than at clerking all routine admissions under duress. After all, there is nothing sacred or necessary about student clerking (often the reverse in the very debilitated!), it is only for the development of *his* clinical skills.

(2) The second misconception of our function, known to all Guy's dressers, is blood taking, which on the new smaller medical firms is soon to become a full time job. The employment of technicians, releasing many hours a week to the student, would be an excellent opportunity for the introduction of medical topic teaching, or other subjects, coinciding with the firms.

One despairs of change though when one hears of clinicians who would gladly burden the student (sorry, I mean dresser) with routine B.P.s and pulses. To what purpose? Who can say except those who view medical education through the blinkers produced by an education received in the 30's and 40's. One concedes of course that proficiency with the No. 1 needle and disposable razor is well developed by this archaic approach to medical education!

One final point to forestall the jibes of "sour grapes". Yes, I, too, was one of the 57 per cent.!

Yours faithfully,

CHRISTOPHER J. BENNETT.

The East Wing,
Guy's Hospital.

White Coats

SIR,—We would like to raise once again the perennial issue of students wearing white coats while engaged in clinical work on the wards. Nearly a year ago a survey of in-patients at Guy's was conducted to find out their views on student appearance (*Gazette*, 20th June, 1970). This indicated that the majority of patients preferred students to wear white coats. Despite criticisms of this survey, there are strong arguments in favour of white coats. Regardless of the variety of fashions and hair length, medical students would be instantly recognised as doctors in training. This uniformity of appearance is probably more professional and more likely to inspire confidence in apprehensive patients.

Nurses are subject to strict rules concerning cleanliness of their uniforms. However, medical students often wear suits on the wards, buses and trains for long periods without having them cleaned. There has been much correspondence in your columns about this in the past.

Many students fear the costs of laundering white coats. However, the cost of cleaning suits and dresses that have caught a spurt of blood (or any other hospital substances), and the general expenditure on day-to-day clothing would be reduced. Perhaps nylon white coats which are hand-washed and drip-dried could be used.

From the female point of view, it would be a great advantage to have a coat in which purses and stethoscopes, etc., could be carried. The few consultants who object to women carrying handbags on rounds would be relieved of their anguish. No male student can carry as much in a suit as he can in a white coat.

The last experiment in white coats failed because of the restrictions imposed on their use. They could not be worn in the Park or in the East Wing, partly because students would be mistaken for housemen. Name badges indicating student status would prevent any confusion.

It is only by further thought and experimentation that white coats for students will be shown to be practical. We have the experience of all the other London Teaching Hospitals to show that they are.

Yours, etc.,

LUCINDA L. JUDD.
ROGER PIETRONI.
TIM KIDGER.

East Wing,
Guy's Hospital, S.E.1.

Fuming Farrow

SIR,—It is odd that cigarettes are sold in the Spit.

I beg the honour to remain, sir, your humble and obedient servant,

S. J. FARROW.

East Wing,
Guy's Hospital.

Cot Death

SIR,—I am grateful to Mr. Arthur Williams for his comments on my Cot Death article. I am sure that he realises that to mention every cause of cot death that has been suggested would have been impossible in such a brief account. Nevertheless, I had not come across any reference to deficiencies of the Bundle of His, and it would be helpful if Mr. Williams could provide me with at least the name of the visiting lecturer and, if possible, references to any published work by him.

As I pointed out in my article, there is a definite seasonal incidence of cot death and any supporter of deficiencies in the Bundle of His as a major factor in cot death would have to account for this.

Mr. Williams also mentioned congenital narrowing of the larynx as a factor in cot death, and interested readers will find an account of this in *World Medicine,* 10th March, 1971.

Yours, etc.,

East Wing,
Guy's Hospital.

NEIL BARBER.

La Spitsia

SIR—May we now look forward to "Schultzbergers" on the menu in the Spit?

Yours, etc.,

24, The Mount,
Guildford, Surrey.

PETER BOWEN-SIMPKINS.

SIR,—In response to Arnold Schultzberger's letter in the issue of 8th May we would like to endorse his view that "Spit" food is of very low quality (indeed, very few would refute this view).

After the last price increase, so low did we think the quality and so high the price, that we, and an unofficial self-appointed committee, believed that the time had come to make a definite change and improvement to the Spit.

A survey of the other teaching Hospitals' refectories was carried out, and in fact Guy's Spit came out of it very badly indeed. The only others worse or equally bad in quality were Charing Cross and The London, and Guys was the third most expensive.

It was felt at various meetings of this committee that things might be better if the Spit were modified so that there was:

(1) A hot counter and a cold counter.
(2) Possibly self clearing.
(3) That the Spit served food more in the snack line, e.g. egg and chips.
(4) That the dining room was made totally available to students and that students be encouraged to eat in the dining room if they wanted a full meal.
(5) That one could buy vegetables separately.
(6) That basically the whole system be made more efficient.

This committee did try. It was granted a hearing by one of "those in high places". But the only tangible effects of the first hearing were: (a) a list of prices put on the Spit notice-board; (b) hot snacks served in the afternoon; and (c) rolls, etc., available at lunch times. A further meeting produced the introduction of "Pay for that which you eat" or rather "Do not pay for that which you do not eat", i.e., 3p reduction if you only have one vegetable.

Nearly everybody agrees that changes in the Spit must be made, but also nearly everybody knows how difficult it is to change anything at Guy's.

The Catering Sub-Committee runs the affairs of the Spit and amazingly manages to do this by meeting only about twice a year. The next meeting of the Catering Sub-Committee is on 4th June, so, if anyone at all has any suggestions or ideas on improving the Spit and the Spit food, please let us have them before that date, via East Wing pigeon holes.

And, keep complaining if you don't find the food satisfactory, otherwise we will never get anything done.

Yours, etc.,

Guy's Hospital Students' Club,
Guy's Hospital, S.E.1.

MISS J. A. P. LEITHEAD,
MR. J. N. E. BUCKLEY
(Catering Sub-Committee student representatives.)

SPORT

BLUES

In the last couple of years there has been considerable dissatisfaction amongst Guy's sportsmen over the awarding of "Blues". The general feeling in this matter has been that whilst the large clubs, such as the Rugby club, award several "Blues" at the close of each season, the smaller clubs seem only rarely to award them.

The procedure as laid down in the Clubs Union constitution, is that a committee be formed of all the "Old Blues" still at the hospital and subsequent to the receipt of nominations from club captains this committee makes the "Blue" awards.

Last October, Robert Goodhart took charge of the administration of the "Blues" committee and wrote to all club captains concerning this year's awards. Sadly, he received only two replies and to date has received no nominations.

Let us hope that now the postal strike is well behind us, that he will be receiving nominations in the near future.

A.R.

CHARITY SPORTS AFTERNOON

Sunday, 25th April.

After three days continuous rain and much nail biting by the organisers, Sunday dawned bright and clear.

Tickets had been selling briskly all that week, and thanks must be extended to all those people who, although unable to come, contributed generously to the charity fund.

FANCY DRESS FOOTBALL MATCH

Greeted by enthusiastic roars, the Angels emerged from the pavilion, resplendent in their fancy dress, to try to maintain their unbeaten record against the soccer club.

They won hands down with their fancy dress, and the prize of the afternoon must have gone to Dave (Legs) Glen, who was last seen disappearing down the road with a tall dark stranger.

After early Soccer Club dominance which resulted in a fine goal from captain Jones, the Angels' unique method of play began to tell, and they started to get on top. Mike Drew defected to the Angels at half-time, and the second half saw two goals from them, a scrambled effort from A. Royston, and one from D. Arnold to give the Angels another victory by 2 goals to 1.

TUG-OF-WAR

Having been kept waiting in the bar for so long (much to their annoyance ??), the motley crew of oarsmen, rugby players and other sundries, came out, and in a death-defying exhibition, had a quick heave.

After much controversy as to whether the Rugby Club had nine or ten people in their eight-man team, they were recorded as the victors.

LADIES' FOOTBALL MATCH

This main event of the afternoon was cheered loudly by the now large crowd of people who watched as two very professional teams of girls ran on to the pitch.

The game, refereed by John Boyle, of Chelsea F.C., was a revelation to many of the spectators. Crystal Palace ladies' team take the game seriously with training sessions and weekly games, and are one of the top ladies' teams in the country. However, the Guy's girls, determined not to be beaten, played some stirring football. After early goals from Crystal Palace, the nurses settled down to some quite tight football, and with a little help from the spectators, the referee, and their own goalkeeper, they finished up only 6—4 down.

The game was obviously enjoyed by all who watched. Any offers for a ladies' branch of the soccer club? All girls interested should give their telephone numbers to Nigel Harradine.

All that was left to do was to draw for the champagne that had so generously been donated by George Phillips, the local wine dealers, and amidst many cheers and boos, John Boyle drew the nine lucky tickets. One of the winners was seen staggering out of the gates clutching his bottle muttering —"Best afternoon I've ever had"—just before he slowly crumpled to the ground.

Thanks must go to all those people who helped with the afternoon—names too numerous to mention—but who helped to make the afternoon an enjoyable and humorous day's sport.

These people and all those who came along on Sunday afternoon helped to raise the magnificent total of £96.50.

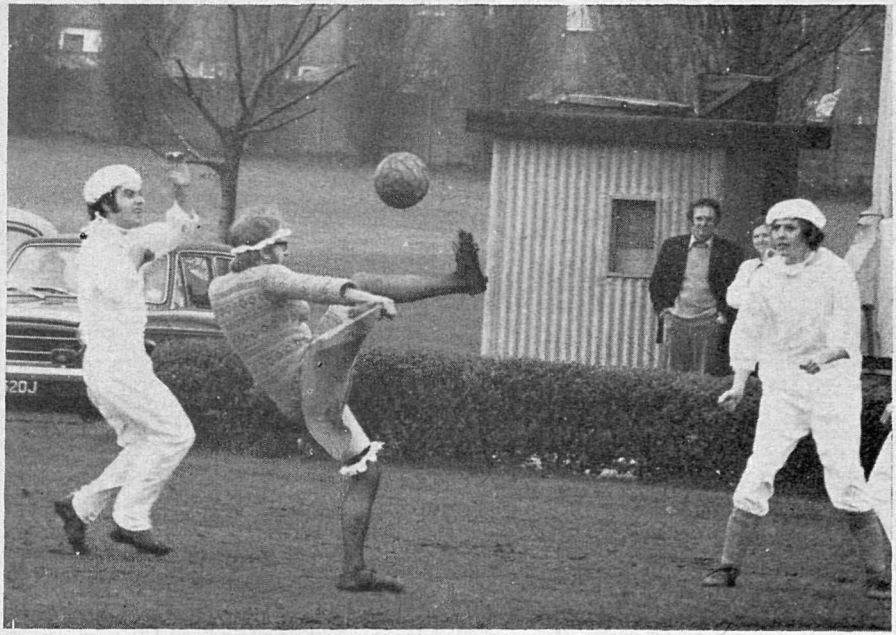
D.J.J.

FANCY DRESS SOCCER MATCH

ANGELS XI v. SOCCER CLUB XI

From the football-purists point of view, this match was undoubtedly the highlight of the Charity Sports afternoon, held recently at H.O.P. It was a confrontation between the more orthodox, staid approach of the Soccer Club and the rather unique Angels' style of play, which to the uninitiated may appear rather scrappy, but to those in the know is soccer in its highest art-form.

The match was kicked off by a strange-looking one-legged man, who promptly fell over, and crawled off the field. The Soccer Club surgeons settled down first, and scored an early goal. A lucky miskick sent the ball into the Angels' penalty area, where it hit the Soccer captain, who was at least 10 yards offside and impeding the goalkeeper, on the side of the head, and trickled over the line for one of the most undeserved goals seen in football since Astle's at Leeds.



The "goal" did serve a purpose in keeping up the morale of the Soccer Club, and how they needed it! The rest of the first half was spent in the Soccer Club's half, and spurred on by lovely Davy Glen, wearing a divine blue chiffon dress, with matching accessories and undies, the Angels were unlucky not to score half a dozen times.

Half-time came and went, and battle was rejoined, with the pattern much the same; Angels' pressure, and panic in the opposition defence. At last justice was done; after a goalmouth melée the ball came out to the *Gazette* Sports Editor, who thundered in a scorching shot from all of two yards, leaving the goalie stunned.

The match then fluctuated wildly, the ball travelling from goalmouth to goalmouth at great speed, and it was anyone's guess who, if anyone, would score the winning goal. Just as a draw was appearing to be the most likely result, the same one-legged gentleman that kicked off received the ball from a throw-in, and hopping past three defenders, somehow propelled the ball in the right direction at the right speed, to leave the goalie grovelling in the mud once more.

Shortly afterwards, the final whistle went, and so the Angels triumphed once more, maintaining their unbroken record for the season. The match, well refereed by Nigel Harridene, was watched by scouts from 27 1st Division Clubs who left, their faces aglow, saying they had never seen anything like it. They were quite right.

Rob Wilson.

The Rugby Club Tug-of-War team
Dave Briggs as "Muscles".

UNITED HOSPITALS BUMPING RACES, 1971

1st VIII

May 10th.—Started 4th in 1st Division; bumped Bart's I; ½ mile.
May 11th.—Started 3rd; bumped St. Thomas's I; ⅔ mile.
May 12th.—Started 2nd; rowed over.

This year's 1st VIII must have been one of the fastest crews Guy's have put on the water in recent years. On the first two nights Bart's and Thomas's were bumped with ease. That the crew finished in 2nd place to St. Mary's was in some minds a travesty of justice, but great entertainment for the scores of supporters on the banks. The 1⅔ length start was rapidly cut to ½ length at the end of the first minute and despite a Mary's burst which restored their lead Guy's came back three more times in a vain effort to bump. At the finish the two crews were ¼ mile ahead of the 3rd and 4th crews which also rowed over. Although it was quite an achievement to come 2nd everyone was very disappointed, however one member was heard to say as he tossed the boat over his head—"We'll have three goes at them next year."

Crew: Bow, P. D. Robinson; 2, P. Stevenson-Moore; 3, M. J. Gleeson; 4, A. Fenn; 5, R. Pinkney; 6, A. Chivers; 7, P. Stuart-Bennett; Stroke, J. C. Miller; Cox, F. Moorhouse.

2nd VIII

The second eight were extremely lucky to bump on the first night as they will no doubt admit themselves. After a shambolic start the rowing did not improve at all, but they seemed to be gaining ground on Bart's II rowing prettily ahead. Just as the cox was about to make a bump, a crab was caught and the boat stopped dead, lurching over to stroke side and out of the stream. The sight of the recovery—likened to a paralytic octopod in Trafalgar Square Fountain—proved too much for Bart's, and Guy's bumped soon afterwards to the surprise and disbelief of all concerned.

On Tuesday night, starting off sixth with London I ahead, they were more relaxed and slightly more serious. As a scratch crew one might expect a few "rough patches", but even so, they bumped London after only two minutes.

They were now placed fifth behind Bart's I determined to bump and win their oars. Although they rowed well, they could not match the poised control or stamina of the first boat gained from many hours of practice rowing together. They rowed-over to finish Fifth overall, and were presented with a medal for the highest placed second crew.

Crew: Bow, J. Monson; 2, D. Preston; 3, R. Newton; 4, J. Burgess; 5, C. Price; 6, N. Hopkins; 7, A. Batch; Stroke, G. Moulding; Cox, D. Evans.

The 1st VIII

3rd VIII

Guy's 3rd VIII started 12th in the 1st division with a scratch crew rowing together for the first time.

Monday night—Arrived late at the start and ran aground. Two members of the crew were still out of the boat pushing it off the bank when the starting gun was fired, resulting in an early bump by Mary's II.

Tuesday night—Started 13th rowing with two substitutes from the 4th VIII. After getting within a canvas of Mary's II, the work faded and we were caught by Vets I in an overbump.

Wednesday night—Started 16th. Easily bumped by a strong U.C.H. crew despite a good start, thus finishing bottom of the first division.

The poor performance was due to the fact that very few members of the crew had done any training and some had not rowed since December.

Crew: Bow, J. Taylor; 2, C. J. Pugh; 3, P. Reid; 4, D. M. Thomas; 5, C. Howard; 6, M. Wink; 7, M. Lilley; Stroke, T. Barnes; Cox, R. Ashman.

4th VIII

Guy's IV began well on Monday bumping the Royal Dental College boat within half-a-minute of the start, this bringing them from 5th to 4th position in the second division. The following evening the crew got off to a magnificent start, closing almost immediately to within half a length of the Vets II boat. This was followed by a long chase which would have almost certainly resulted in a bump had not bow had an accident at the critical moment. On the final night, however, neither the Vets nor the other leading crew turned up, leaving Guy's to row over at the head of the Second Division with no following boats in sight.

Crew: Bow, M. Brown; 2, D. Carman; 3, S. Large; 4, G. Robbins; 5, L. Rabb; 6, K. Freeman; 7, C. Fox; Stroke, D. M. Curtain; Cox, G. Browne.

GUY'S LADIES VIII

The only female element for the Bumps came in the shape of the Guy's Ladies' VIII, who started at position 28 and provided the 6 crews behind them with something well worth chasing.

Monday saw Guy's Sailing Club making physical contact with the Ladies' stern, in spite of three brilliant coxing manoeuvres.

On Tuesday Guy's Angels were kept at a respectable distance, but their superior muscle power eventually enabled them to row past.

On Wednesday a male replacement provided with some extra uplift joined the Ladies in a dependable but unsuccessful bid to hold off a St. Thomas's crew, thus leaving the Ladies in a final position of 31st.

The lack of success was by no means a reflection on the coaching provided by Hugh Fuller—to whom the crew remains indebted.

Crew: Bow, Claudia Roe; 2, Rebecca Michell/David Jones; 3, Charlotte Cavanach/Frances Rochford; 4, Fiona Odle; 5, Margaret Walter; 6, Mary Wade; 7, Kathryn Marshall; Stroke, Elizabeth Ryman; Cox, Kathleen Spencer.

ANGELS' CREW

Yes, friends, the Angels have triumphed again. Incredible as it may seem they have yet again achieved outstanding prowess in another branch of the world of sport by being the only Guy's crew of seven who participated, and, indeed, one of the only two crews of all those competing from the other hospitals, to obtain three bumps and thus deservedly win their oars.

Their feat was made even more memorable by the fact that only Gross and Burlinson had ever done serious competitive rowing before (although at times these two showed very little evidence of having done any) the rest of the crew's experience being limited to a similar tournament that took place last year.

An impressive training (nil) and practice (1½ hours) programme probably accounted for the phenomenal success of the Angels' crew. Weeks(?) before the event on the river at Chiswick in both 4's and 8's, practice was rewarded by a change from desolute to relatively mild ataxia and incoordination with the added bonus of blisters (Royston managing to get one in a most unusual place), aching muscles and the cox as an enemy.

Special mention must be made of Fleet who, during a practice session, whilst attempting to rid himself of a "crab" by ejecting himself from the rear of the boat and cleansing himself in the sacred waters of the Thames, was mistaken by Ryan for a piece of driftwood. Ryan accordingly treated this hazard with an oar swept gracefully on to the top of Fleet's driftwood-looking head. The rest of the crew thought the incident a huge joke and were falling about with mirth, totally ignoring the flounderings of the dazed body in the water. Luckily, Fleet suffered only injured pride from this unfortunate episode but not five minutes later, as if to show it was not just a once lucky trick, he gave a repeat and again well received performance after another bad attack of "crabs".

That the Angels started quite low on the table (second from bottom) in no way detracted from their magnificent achievement; and the uncertainty of the exact personnel of the crew sometimes only a few minutes before the start showed what a resourceful and tactical plan the team were working to.

The first evening's entertainment on Monday had the Angels behind a vastly inferior Thomas's crew whom they quickly bumped within fifty strokes of the start. The Angels would have bumped even earlier had it not been for a blatant act of sabotage by a Thomas's supporter's motor dinghy that caused havoc to our oarsmanship for a short while.

An eventful Tuesday night saw the Angels bumping the unlucky Guy's Ladies' crew with, again, not much difficulty.

On the final evening the Angels were trying to bump a Bart's crew, which they did with the customary minimum of skill and maximum of brute force and effort. The evening was completed with the usual attempt at drowning the cox with water and the rest of the crew with alcohol.

Although the Angels obtained their three bumps, they did not in fact hit any of their "bumped" boats. However, just to show spectators and the referee launch that they could, having obtained their bump on the Tuesday, they decided to have a little merriment by ramming the Thomas's boat they had bumped the previous day. The irate Thomas's crew did not find this jest at all amusing and complained bitterly to the referee launch. This complaint was thought uncalled for by the spirited Angels' crew, who showed their dissatisfaction by an endearing barrage of typical Angels' ribald witticisms, noises and choice phrases for which they are so justly famous.

In conclusion, a fine effort by a talented Angels' crew and our thanks go to all those people who gave so much of their valuable time in support and the making of a really enjoyable three days rowing.

Crew: Bow, R. Wilson; 2, D. Gatland; 3, P. Watkin; 4, A. Royston; 5, C. Ryan; 6, R. Burlinson; 7, M. Epsom/H. Fleet; Stroke, M. Gross; Cox, K. Clifford.

R.A.B.

SAILING CLUB VIII

The U.H. Bumps provided the opportunity for the Sailing Club to display its versatility on the water. Apart from their illustrious cox, only one of the eight had ever dared step into such an unseaworthy craft before.

After a smattering of "crabs" they arrived at the start on the Monday evening to find they had been seeded 29th, directly behind the Ladies' eight. The Sailing Club elected to start without their stroke, Bob "crab" Elliot, and on the gun they shot off to an immaculate start. The ladies put up a brave fight, but only a few strokes were necessary to make them submit.

On the second night they decided to allow stroke to row as they faced the mighty Bart's VI eight. Again, superior style and coxing won the day and the Sailing Club eight bumped again.

The last night provided them with their biggest challenge, namely a stylish St. Thomas's eight. Within seconds of the start, Guy's had closed the gap, but unfortunately St. Thomas's bumped first. Luck was not with them as they sped on, chasing the crews higher up the ladder. Again they got within striking distance, but again they were beaten to the bump. However they were not discouraged and rowed on strongly to gain a very creditable "row-over", having moved from position 28 to 26 in three nights.

Thanks must go to the cox, Paul Lacey, who spent many a sleepless night worrying about his crew, also to Ted Harland, the "pusher", and to all those physios who gave the team so much physical encouragement.

Crew: Bow, B. Jones; 2, P. Duplessis; 3, M. Bye; 4, B. McLeod; 5, G. Barker; 6, R. Fitton; 7, P. Meakins; 8, Ted Fox/Bob Elliott; Cox, P. Lacey.

G.B.

HOCKEY

SPIROCHAETES' EASTER TOUR

On the Thursday before Easter, Guy's Hospital saw a great exodus of some of the best hockey players in London. Unfortunately they didn't come with us.

After a gruelling journey down to Torbay with Martindale chaffing at the bit because he didn't get his cream tea at Honiton, there was only one thing to do. Get to the Pulsham Arms.

However, before we could scramble to our cars our hotel proprietor just wanted to ask us one question, "Ahhhm, is that fellow Aide coming this year?" Oh well, that was his Easter ruined.

Still down at the Pulsham it was good to hear once again the ring of "Scrumpy and dash, please", and show Tommys what bad arrows they threw, and how lucky they were to win the Hospitals' Cup.

Now it was obvious we had to be in trim for the first game the following morning, so with extended invitations from the Tommy's Boys we moved off to see our converted friend and hotelier Arthur, for a few, well, more beers.

What a welcome we received from our jean clad friend Arthur. He had a special speech all ready for us.

"Get out you Spirokitees, I don't want any trouble here. If I get any trouble I'll hit any of you over the 'ead with a bottle."

How pleasing it was to see Arthur in such magnificent form. Quietly we reassured him there weren't any Spirochaetes in his bar and got down to the serious business of drinking.

It was also good to see that the Millers hadn't let us down again. What a woman, very game, a different pair of hot pants every night!!

Friday saw the ghastly sight of eleven players holding their heads and not their hockey sticks. But my, how sea air freshens. The Spiro's started running and looked good. At half-time it was 0—1, and then in the second half, much to their own dismay, Brownley and our guest player (yanked out of bed by Weedon from the only five-star hotel in Torbay) slotted in the vital goals.

This was truly fantastic; more goals than we scored in all our matches last year and the first win for two years. Now we could hold our heads up to the organisers who had included us in their special 21st Anniversary programme as the only team last year not to win.

Could this be our year.

But how the beer flowed and oh, how the head rolled as we got trounced in the afternoon.

After our superb welcome from Arthur on Thursday, Bell, now working at Plymouth, couldn't wait to see his life-long friend Arthur. So with alarming time-keeping once again at 11.10 p.m., we arrived at Arthur's. Bell, with dark glasses, as the moon was strong, followed us in. With speed that only a true Spirochaete is capable of, Arthur side-stepped the bar, dropped his left shoulder and Bell was no longer in Arthur's.

So with the scrumpy going down well and sleep being the last form of entertainment, we continued to suffer in our hockey. Although we had some interesting combinations from Das.

It was not until our last game on Monday that we managed another point. But with the glorious weather and the hot pants at Arthur's, the boys were in no fit state. Having bettered ourselves on last year, we felt well satisfied and enjoyed every minute of an eventful three days.

Team: Cottingham, Chassack, Martindale (capt.), Gillham, Das, Weedon, Bell, Crawshaw, Brownley, Tas, Holland.

A.A.H

PREVIEW OF THE CRICKET SEASON, 1971

At the time of writing, the season has already got off to a very reasonable start. Four matches have been played, two of which have been won and one lost.

We have a wealth of cricketing talent at the hospital which augurs well for the season. Robert Goodhart, who is himself a first-class player, captains the side for the second season. He also captains United Hospitals, and it says much for Guy's that in the first U.H. match, there were three Guy's men in the team.

However, as with all Guy's sport, there appears to be a certain amount of apathy towards cricket. We have a top class fixture list, and in order to be able to win these matches, we need to produce our best sides regularly. Many good players prefer to play for their own clubs, or cannot find the time to play regularly for Guy's. This is a slightly selfish attitude, as future cricketers will be the ones to suffer. It is hoped that all cricketers will make an effort to support the hospital this season.

The second XI once again appear to be embarking on an enjoyable summer session. Whatever criticisms may be levelled at this team, they certainly love the game, and that, after all, is the idea of any sport.

H.O.P. is in wonderful condition considering the strain that is put on it during the winter. We have a wonderful groundsman in Stan Weller, and our thanks go to him, not only for the support he gives to cricket, but to all other sports. I always feel that there is a tremendous potential going to waste at H.O.P. Supporters are always welcomed at cricket matches, and if players continue to bring along wives and girl friends, H.O.P. could become much more of a club than a changing facility, which is all it really serves as at the moment.

Finally a plea to all cricketers new to the hospital to think about playing for Guy's. No club can keep going without a continuous intake of "fresh blood".

CHRIS LANGDON.

MATCH v. PUTNEY

H.O.P. 1st May. Won.

Putney decided to bat first, and with some good bowling and fielding, were dismissed for 84. Henriques bowled particularly well to take 4 for 32. Gillham, exhausted after scoring two threes on top of his wicket-keeping stint, was out cheaply, as was Rees. Powell-Jackson looked in good form, but was bowled, hitting across the line, but Langdon (24 n.o.) and Goodhart (25 n.o.), took Guy's to a comfortable 7-wicket victory.

MATCH v. LONDON HOSPITAL

H.O.P. 2nd May. Lost.

It was probably a mistake to bat first on this wicket, which Guy's did. It had a certain amount of lift and took some spin, but it was largely bad batting which was responsible for the Guy's all out total of 92. Hoyas batted sensibly for 20, but no one else really got his head down. The London knocked off the runs for five wickets (Ramsey took 4 for 42), but it was by no means an easy victory.

Since the match finished early, a 10-over match was played. Some amusing episodes were seen as each member of the team bowled one over. Guy's won comfortably as Carter Croft (still in rugger clothes from the Middlesex Sevens!) hit some resounding blows!

MATCH v. WANDERERS

H.O.P. 5th May. Won.

This could well prove to be one of the best victories of the season. On a dubious wicket, Guy's decided to bat. With Holland run out in the first over, things looked grim. However, Fitton, who was joined by Oram after Evans

was out, managed to hang on until lunch, although they did not score very fast. Fitton scored 40 and Goodhart made a good 58, but with no one else in touch, Guy's were out for 169, which did not seem nearly enough.

The Wanderers, thinking that they had a certain victory on their hands, reversed their batting order. With 20 overs left, they needed 100 to win with eight wickets standing. Guy's, however, did not give up, and with Davies and Ramsey bowling very sensibly, the wickets began to fall. This was primarily due to some wonderful fielding, which kept the situation tight, and some truly magnificent catching. Goodhart caught an impossible catch, and Clifford-Jones took three very good ones.

With the Wanderers needing 50 to win off seven overs, Goodhart relieved Davies, who took one for 68. This was a gamble which could well have failed; however, he took two wickets off his first two balls. The first was a skied catch to Reynolds, who took the ball with amazing ease—he did not see the other ten players on their knees praying as the ball descended out of the sky to him! Goodhart ended with 3 for 0, and Ramsey with 5 for 68, and Guys won with two overs left to play—a really great win. There were, in all, eight catches, which, I suppose, proves that the old motto is true.

CHRIS LANGDON.

GOLF

THE LONDON UNIVERSITY GOLF CHAMPIONSHIPS, 1971

Beaconsfield Golf Club, Wednesday, 5th May.

Six Guy's golfers entered the championships: Dai Rowley-Jones, Neil Davies, Richard Ibbetson, Ted Bray, Paul Powell-Jackson and Pete Matthews. The first four were Guy's team for the Team Championship.

The Guy's golfers, having been fortified by a 10 o'clock breakfast at the Copper Kettle at Beaconsfield, arrived at the course and undertook some strenuous pre-round practice.

The first Guy's three-ball, with its distinctly Welsh flavour, consisting of Dai Rowley-Jones, Pete Matthews and Neil Davies, was notable for a fine round by Dai Rowley-Jones, who found the holes the size of dustbins and shot a 74 to take the lead in the morning round. Neil Davies' round was similar to the contents of a dustbin, and was seen proceeding round the course at right-angles, due to a vicious attack of the socket; he fought manfully against this affliction for a 78. Richard Ibbetson was wondering where all his good golf had gone when the golf course jumped up and hit him for an 80. While Ted Bray started bravely with a birdie 3, but struggled rather hard for an 83.

In the afternoon, three singles were played, since the two three-balls had made rather slow progress. The leader at lunch steered clear of alcohol and was seen nervously pacing about on the practice putting green, but, showing no signs of nerves he "boxed" a real "tram-liner" from off the green at the first for a birdie 3. The next two holes caused Dai some trouble, but with some very fine iron play, he held on well, averted a terrible disaster at the tenth and played steadily to finish in 77 and a total of 151. Richard Ibbetson, having been attacked by the golf course in the morning, returned the compliment in the afternoon and returned a 73. While Neil Davies, having rid himself of his terrible affliction (not Dai Rowley-Jones but his fit of shaking) played very well for a 74. Ted Bray, meanwhile, spent a lot of time playing in the sand and returned an 86.

The team was very well supported by Paul Powell-Jackson (85, 83) and Pete Matthews, who enjoyed himself and took 87 in the afternoon.

Guy's won the team event for the third consecutive year, the best three totals counting.

Guy's players finished 2nd, 3rd and 4th in the Individual Competition; 2nd, Dai Rowley-Jone, 74, 77=151; 3rd, Neil Davies, 78 74= 152; and 4th, Richard Ibbetson, 80, 73=153.

R. J. IBBETSON.

RUGBY

KENT SEVEN-A-SIDE RUGBY TOURNAMENT

At Gillingham, 24th April.

With Twickenham only a week away, the Guy's Seven badly needed some serious match practice, and a good run of success in this competition.

Their luck was in as the first round game against Old Erithians provided a gentle warm-up as the team cantered to a 26—3 victory. The inclusion of Evans as hooker paid off now and later as the powerful Price, Ross and Novak revelled in the plentiful supply of possession.

The next two games, against Old Dartfordians, the holders, and Midland Bank followed the same pattern, with Price and Croft leading the scoring. Results: 21—0 and 19—3.

It was a different story in the semi-final, however, when Guy's faced a little-known but aggressive Thames Polytechnic side. The Poly. succeeded in rattling the more fancied side and led 3—0 at half-time. Fortunately, order was restored in the second half, and tries by Novak and Thorburn (now limping with a pulled hamstring) gave Guy's a 10—3 win.

In the final, Barough substituted for Thorburn and ran in 3 tries in a fine performance in which Guy's thrashed a slightly weakened Blackheath Seven by 23—6, and won back the trophy last won by the Hospital in 1953. John Ross had a superb final game and contributed much by his goal-kicking.

Team: 8, J. Novak; 7, R. Barough; 6, J. Ross; 5, J. Price; 4, C. Croft; 3, A. Fallowfield; 2, G. Evans; 1, C. Thorburn.

MIDDLESEX SEVEN-A-SIDE TOURNAMENT

At Twickenham, 1st May.

Guy's, as the oldest club, were invited this year as a guest side in the final rounds at Twickenham.

In the 5th round, Guy's were drawn against one of the "giant-killers" of the preliminary rounds—Old Dartfordians. From the kick-off, however, it was evident that the "giant-killers" were about to perish, and after only two minutes, Evans plunged over to the roars of a sizeable Guy's contingent. After this good start, apathy set in, and the Old Boys equalised. Jolted by this and some inspired linesmen's decisions, Thorburn and Croft made the winning margin 13—5.

The quarter-finals meant facing a London Scottish team who had already accounted for a useful Wasps Seven. The earlier encounters were even, and a try by Price was equalised after an interception. From here on, however, as viewers of B.B.C.2 will have seen, Guy's played probably the best rugby of the day and some fine running by Barough, Croft, Price and Novak gave Guy's the highest score of the day, 30—3.

The semi-final opponents were a very skilful yet physical Harlequin Seven who, in front of their own crowd, proved too powerful on the day. Suddenly the ball wouldn't run for the team and after one certain, and one possible try was cancelled out by odd refereeing decisions, the Harlequins were victors, 25—3. Although they lost this semi-final, the Hospital reaffirmed themselves as a first-class side and won many new fans with their entertaining play.

Team: 7, R. Barough; 6, J. Ross; 5, J. Price; 4, C. Croft; 3, J. Novak; 2, G. Evans; 1, C. Thorburn.

HOSPITAL INFORMATION

GUY'S HOSPITAL

Applications are invited for the appointment of *locum junior registrar* in cardiology for the period 1st June to 30th September, 1971. Application forms are obtainable from and should be returned to the Superintendent, Guy's Hospital not later than **28th May, 1971.**

GUY'S HOSPITAL

A course of study in Anatomy, Special Anatomy, Physiology, Pathology and Microbiology will be held in preparation for the Primary F.D.S. Examination. The course will commence in mid-September, 1971 and extend over a period of approximately 15 weeks; classes will be held at 5.15 p.m. on up to 4 evenings per week. The number of students will be limited to 12. The fee will be £21.00. Forms of application are obtainable from the Dean of Dental Studies, Guy's Hospital Dental School, London, S.E.1, and should be returned to him not later than **Thursday, 1st July, 1971.**

GUY'S HOSPITAL
HOUSE APPOINTMENTS
JUNE 1st, 1971

House Physicians

Dr. Mann, Dr. Scott and Dr. Clark	Mr. W. J. Morris 3 *months* Mr. J. A. H. Wass 6 *months*
Dr. Hardwick, Professor Trounce	Mr. T. W. Higenbottam 3 *months*
Dr. Cameron and Dr. Ogg	Miss S. A. Lange 6 *months*
Dr. Houston, Dr. Knight, Dr. Deuchar and Dr. Grimble	Miss A. W. Godsmark 3 *months* Mr. B. R. Kenning 6 *months*
Dr. Kauntze, Dr. Joiner, Dr. Barry and Dr. Sowton	Mr. J. Rawlinson 3 *months* Mr. R. J. Wainwright 6 *months*
Professor Lessof and Dr. Grahame	Mr. R. A. Gude 3 *months* Mr. R. G. A. Behrman (subject to qualification) 6 *months*

House Surgeons

Professor Sir Hedley Atkins	Miss A. P. Hill 3 *months*
Mr. Blackburn and Mr. McArthur	Mr. C. G. Rowland 3 *months*
Mr. Lawrie	Mr. A. J. Camm 6 *months*
Mr. Glover and Dr. Wayte	Mr. D. F. M. Thomas 3 *months*
Mr. Beard	Miss D. C. T. Watson 3 *months*
Mr. Maynard and Mr. McArthur	Mr. P. W. L. Ribet 6 *months*
Mr. Ellis	Mr. J. L. Bates 3 *months*
Mr. O'Flynn and Dr. Wayte	Mr. D. MacDiarmid 6 *months*

House Surgeon to the Breast and Plastic Surgery Units

Mr R. A. Blackwood
3 *months*

Gynaecological House Surgeons

Mr. S. J. D. O'Keefe
3 *months*
Mr. S. R. D. Coles
6 *months*

Throat and Ear House Surgeons

Miss G. L. Hoare
3 *months*
Mr. G. T. Cheney
6 *months*

Orthopaedic House Surgeons

Mr. M. G. Sutton
3 *months*
Mrs. L. J. Rockall
3 *months*
Mr. N. A. G. Jones
6 *months*
Miss I. D. Cormac
6 *months*

Each Orthopaedic House Surgeon will spend six weeks at New Cross Hospital.

S.H.O. to the Renal and Transplant Units

Mr. R. D. Forrest
3 *months*

Genito-Urinary House Surgeons

Mr. J. De Carteret
3 *months*
Mr. M. M. Henry
6 *months*

Children's House Physicians

Mr. N. C. B. Howell
3 *months*
Mr. M. F. M. Bamford
6 *months*

Casualty Officers

Mr. M. J. Hillier
3 *months*
Mr. H. Horrocks
3 *months*
Mr. F. O. Nwator
3 *months*
Mr. A. S. Purandare
3 *months*
Mr. N. J. Lattimer
6 *months*
Mr. J. A. R. Pook
6 *months*

Resident Obstetricians

Mr. J. B. Kelynack
3 *months*
Mr. R. W. Neale
6 *months*

Neurological House Physician

Mr. J. R. Price
3 *months*

Dermatological House Physician

Mr. D. Ogilvie
3 *months*

House Physician in Child Psychiatry

Miss R. P. Doody
3 *months*

House Surgeons to the Thoracic Unit

Mr. A. Hirsh
3 *months*
Mr. A. V. Lalani
6 *months*

House Physicians in the Department of Psychological Medicine

Mr. M. Redfern 1.4.71—30.9.71
Mr. M. Mubbasher 1.4.71—30.9.71

Resident Anaesthetists

Miss A. M. Skelton
3 *months*

Mr. J. R. Wedley
3 *months*
Mr. R. P. H. Dunnill
6 *months*
Mr. M. A. Knight
6 *months*

Senior House Officers to Nuffield House
Mr. J. A. Vale
3 *months*
Mr. M. F. Shiu
6 *months*

Children's House Physicians at Evelina Hospital

Mr. G. Stern	1.2.71—31. 7.71
Mr. A. C. L. Fraser	1.4.71—30. 9.71
Mr. K. G. E. Brown	1.6.71—30.11.71
Miss S. E. Read	1.8.71—31. 1.72

Casualty Officer at Evelina Hospital
Mr. M. Salimi
3 *months*

ST. OLAVE'S HOSPITAL
House Physicians:
Mr. R. J. Rycroft
3 *months*
Mr. T. J. Storrs
6 *months*
House Surgeon:
Mrs. F. E. Jones
6 *months*
Senior House Surgeon:
Mr. D. J. Johnson
6 *months*
Gynaecological House Surgeon:
Miss C. Roberts
3 *months*
S.H.O. in Psychiatry:
Mr. S. Joshua
3 *months*

NEW CROSS HOSPITAL
House Physician in General Medicine and Geriatrics:
Mr. J. R. M. Ross
3 *months*
Miss M. J. Van Essen
6 *months*
Orthopaedic House Surgeons:
See under Guy's
Senior House Officer to Rehabilitation Unit:
Mr. A. Bhoomkar
3 *months*

BECKENHAM HOSPITAL
House Physician:
Mr. N. I. McNeil
3 *months*
House Surgeon:
—

GREENWICH DISTRICT HOSPITAL
House Physician to Dr. Mallinson:
Miss C. Thorne
6 *months*
House Surgeon to Mr. O'Flynn, Mr. Wilson, Mr. Hollis and Mrs. Wengraf:
Mr. D. A. Rosenberg
6 *months*

HITHER GREEN HOSPITAL
House Physicians in General Medicine and Infectious Diseases
Mr. M. Taylor-Pearce
3 *months*
Mr. C. C. Baker
6 *months*

LEWISHAM HOSPITAL
House Physician to Dr. Price:
Mr. J. M. Morsman
6 *months*
House Surgeon to Mr. Lynn Evans:
Mr. D. Bellamy
6 *months*
House Physician to Dr. Roberts:
Mr. C. J. Noble:
6 *months*
House Surgeon to Mr. Ivo-Smith:
Mr. B. M. Crichton
6 *months*
House Surgeon to Mr. France, Mr. Bingold and Mr. Monty:
Mr. R. H. Mackay
6 *months*
House Surgeon to Mr. Le Brun:
Mr. A. K. Addison
3 *months*
House Surgeon to Mr. Cavendish:
Mr. M. A. Mansell
3 *months*
House Physician to Dr. Llewellyn Smith:
Mr. M. J. Forbes
3 *months*

MILLER HOSPITAL
House Physicians to Dr. Hartley and Dr. Bassadone:
Mr. A. G. Samuel-Gibbon
3 *months*
Mr. M. N. Vellacott
6 *months*
(S.H.O.) Mr. J. D. Martin
6 *months*
House Surgeon to Mr. Candy and Mr. Gwynne Evans:
Mr. J. K. Mackenzie
(subject to qualification)
6 *months*
House Surgeon to Mr. O'Flynn and Mr. Fyffe:
Mr. G. Peters
6 *months*

ORPINGTON HOSPITAL
House Surgeon with Dental:
Mr. A. R. Valentine
6 *months*
House Surgeon with E.N.T.:
Miss R. C. S. Dow
6 *months*
House Surgeon with Gynaecology:
Mr. J. G. G. Hanley
6 *months*
House Surgeon with Orthopaedics to Mr. Boxall and Mr. Lam:
Mr. S. D. Horsley
6 *months*
House Surgeon to Mr. Walker-Brash and Mr. Lam:
Mr. R. D. Ward
6 *months*

PEMBURY HOSPITAL
House Surgeon to Mr. Gibson and Mr. Lavy:
Miss R. J. Thorburn
6 *months*
House Physicians to Dr. Miller and Dr. King:
Mr. J. M. Ruddock
3 *months*
Mr. A. I. Attwood
6 *months*

ST. HELEN'S, HASTINGS
House Physicians:
Miss A. Ironside
6 *months*
Mr. P. Reinhold
3 *months*

ST. NICHOLAS, PLUMSTEAD
House Physician to Dr. Scott:
Mr. N. Longhurst
6 *months*

P. J. HELLIWELL,
Superintendent.

5th May, 1971.

PASS LIST

UNIVERSITY OF LONDON
Ph.D.

N. C. Sethi — Annette Skinner

M.D.

P. R. Grob

ROYAL COLLEGE OF PHYSICIANS OF LONDON
F.R.C.P.

B. H. Bass
J. H. Baylis
J. S. Cameron
T. R. L. Finnegan
R. Goulding
I. S. Hodgson-Jones
D. N. Leeming
G. H. T. Lloyd
H. G. McComas
D. A. F. McGill
J. K. Morgan
J. F. Soothill
G. E. Sowton
J. S. Stead
W. Van't Hoff

ROYAL COLLEGE OF SURGEONS OF ENGLAND
Primary F.F.A.

R. S. B. Bramwell — G. A. Corbett

EXAMINING BOARD IN ENGLAND
Final L.R.C.P., M.R.C.S.

Pathology

W. Edmonds
P. G. Jackson
E. M. Reuben
Loretta Salter
J. H. P. S. Sargent
A. J. Shellim
C. R. White

Medicine

B. R. Beaumont
A. J. L. Brain
Penelope Brain
Margaret L. Cann
L. P. Harrison
G. M. A. Heaton
Alison Ironside
P. G. Jackson
Sarah A. Lange
E. G. Latimer-Sayer
A. M. Ross
Loretta Salter
J. H. P. S. Sargent
A. J. Shellim
P. J. E. Smyth
K. O. Thompson

Surgery

S. E. T. Bowden
P. R. Evans
A. Fenn
S. R. Hammond
D. M. Hunt
Alison Ironside
B. V. Martindale
P. Matthews
T. D. F. Mendis
G. L. Prior
L. Pstrossova
L. A. Toby

Midwifery

Penelope Brain
P. R. Evans
S. R. Hammond
A. N. Hooker
P. G. Jackson
T. D. F. Mendis
G. L. Prior
E. M. Reuben
J. H. P. S. Sargent
A. J. Scourfield
A. J. Shellim

PERSONAL

LEASE of three-room flat in Trinity Church Square available immediately, married couples only. Please apply Box 5/5.

PART-TIME Dental Surgeon associate required for busy Caterham practice. Own laboratory, considerable amount of private work. Own nurse and complete clinical freedom. Blade implantology used. Excellent percentage offered. Tel: Caterham 43999.

FLAT TO LET in Blackheath. Doctor from Bart's going to Norwich for six months would like to let his smashing flat to three people who will look after it. Fully furnished, three large rooms, K. and B. and fabulous William Morris loo. Television, telephone, etc. etc., use of garden, nice neighbours. All for £16.50 per week, including rates but excluding gas, electricity and telephone. Anyone interested ring Dr. J. Mackinnon at Bart's, or his charming wife at 858-7814.

BIRTH

WILD—On 6th May to Judy (née Laws, B.D.S.), and Roger Wild, a daughter, Megan Jane.

DEATHS

COHEN—Major Louis C. Cohen, qualified L.D.S., R.C.S. (Eng.), Guy's 1913, 11, Llwyn Y Grant Road, Penylan, Cardiff, passed away on 24th April, 1971.

ROBINSON—S. Emmanuel Robinson, qualified M.R.C.S., L.R.C.P., Guy's 1926, 14, Browwydd Avenue, Penylan, Cardiff, passed away on 4th May, 1971.

CHANGE OF ADDRESS

Judy M. Wild (née Laws) B.D.S., to 20 Dane Close, Thetford, Norfolk.

We would like to remind our readers that all copy for inclusion in the "Gazette" must be received eight days before publication date.

Copy may be sent to us c/o The Front Lodge, Guy's Hospital.
Birth, Marriage, Death and Change of Address notices are without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, please indicate whether or not this should be published.

Personal notices 5p per word (pre-paid) (minimum £1.05).
Non-subscribers will pay £1.05 (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

EDITORS N. D. S. BAX and A. M. TURNER
NEWS EDITORS R. M. DARLING and J. L. LEWIS
SPORTS CORRESPONDENT A. M. ROYSTON
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TEN PENCE VOLUME 85 NUMBER 2162

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

On Friday, 21st May, one could have seen in Guy's, in real life, activities that had a likeness to the film "Z". The difference between the film and the occurrence about to be described was that the former showed a seemingly irretrievable situation whereas a recurrence of the event that took place in Guys' can still be prevented.

On this particular Friday, two men, both over six feet tall and in their late twenties, were walking from the Colonnade towards the Great Maze Pond. At first glance they appeared like policemen as they were wearing black boots, dark blue trousers and light blue shirts. The shirts had epaulettes and metal objects on them similar to policemen's numbers. This, however, was where the resemblance ended, for the two men were wearing black riot squad helmets with straps and large chin pads. One man was brandishing a two foot long baton, whilst the other carried a large black case, probably containing money. Their overall appearance was menacing and disquieting. If these two men had been walking in Borough High Street the Police might well have asked them for justification of their behaviour.

A South African passing by at the time expressed considerable amazement that anybody behaved in such a way in this country.

The Hospital obviously wishes to protect its money and, as any large concern, employs security companies to transport money. But who determines how much licence the security men get on hospital property? If it is the Hospital, then they have sadly misjudged the effect on both patients and staff of this sort of invasion. If it is the security company then it is perhaps time some action was taken at a national level to prevent the irresponsible and arrogant type of behaviour to which we have been subjected.

The conduct of these two security company men had strikingly sinister resemblances to that witnessed both in the past and at present in countries less free than ours—conduct that has been readily and necessarily condemned by the free world.

The Park is an extremely pleasant place but will not remain so if we tolerate a continuance of these para-military activities.

Meat or Poison?

You do not have to be a driver to see that a man is driving round a bend too fast. Indeed, the observer is often in a better position than the effector to judge the chances of success of a venture. The question of who is the best judge of an individual's actions is the central issue of the confused and very much protracted controversy over the legislation of marijuana.

Recently we read on the front pages of the newspapers that half of the student population of this country had taken the drug. It is a sour paradox to the virtuous defenders of Western democracy that the Army of Might, which was to purge South Vietnam of the Communist menace, has become, according to all good reports, alloyed, to an extent not accurately assessable, with a diet of cannabis.

Society's ideals, where they should have been strongest, have been found to be weakest. Many have decided before hearing the medical evidence, which could well take many thousand animal-years before it is complete, that the confrontation with an altered sense of reality is worth the experimental risk, unknown as it is. Many would say that the fact that people have taken the decision to try the drug under such conditions proves that they are incompetent to take such a decision and should therefore not be allowed the freedom of choice.

But who should make the decision? Society can ask a psychiatrist if such an experience is good for the mind, a clinical scientist if marijuana is harmful to the body, a priest if it illuminates the soul, and a novelist if it provokes a rich imagination. From all these sources we shall doubtless receive varying answers, probably some encouraging and some discouraging. Already we have evidence that many thousands, rightly or wrongly, have decided that, as Dr. Samuel Johnson said when talking about indulging in the excesses of wine :

"Every man is to judge for himself, according to the effects which he experiences."

NEWS IN BRIEF

What kind of doctor ?

Some may remember a B.B.C. documentary on medical education called "What Kind of Doctor?", which was filmed at St. Thomas's, and shown on B.B.C.2's "Horizon" in March. It elicited considerable comment, mostly critical, in medical circles at the time. About a fortnight ago a small group from Guy's, including five medical students, were given a private showing of the film at the B.B.C. centre at the White City, by Brian Gibson, one of the film's producers.

It was surprising, after the reception that the film had received when shown on TV, that most present agreed with the main message of the film, i.e. that traditional undergraduate medical education, concentrating as it does firstly on the study of the human animal as a box of biological tricks, and then on physical disease, is largely irrelevant to the needs of the community, which are far more related to social and psychiatric medicine. Although it was felt that the film had possibly portrayed St. Thomas's and its students in a rather unfair light, Mr. Gibson said that he and his co-producer had tried to reproduce the impressions that they had gained during the course of their research and filming at St. Thomas's.

Most of those present were impressed by Mr. Gibson's willingness to give his time for discussion of the film, his apparent honesty in talking about his motives in making it and his justification for the film's "bias". In fact, one wondered what all the fuss had been about.

Student Dynamism

Last week the Student Medical Education Committee invited applications for its annual elections. The student body, as is customary, responded with a flood of enthusiastic, dedicated, idealistic (yet hard-headed and practical) applicants, all eager to represent their fellows and convert their radical (yet reasoned and constructive) views on medical education into measures which will benefit both current and future medical students. Of the six years of students represented, two actually put forward MORE applicants than there were places for them! No doubt this unusual occurrence will unleash a tornado of canvassing (from soap-boxes in the Spit, as well as national Press and TV) as candidates fight bitterly for those precious seats. Of the remaining four years, only three didn't manage to provide as many candidates as places available, but this can be explained by these years' greater pre-occupation with far more important matters such as the suitability of the Blackwood convention when playing a high-low singleton (whatever that means).

Such enthusiasm makes one feel truly confident that the future of medical education is in such good hands.

Dr. Elizabeth Clyma

Dr. Liz Clyma, who qualified at Guy's two years ago, has been awarded the John Stokes Research Fellowship, tenable for 3-5 years, and is now doing research concerned with electroconvulsive therapy, particularly the unilateral variety, and cerebral dominance, at Sheffield University.

A first-class combination?

It has been suggested that the Rugby Clubs of King's, Thomas's and Guy's should be amalgamated to form a South London Hospitals' Rugby Club, whose First XV could successfully contest the first-class fixtures which Guy's and Thomas's are at present in danger of losing.

Students' Grants—the Latest

On Friday, 21st May, Mrs. Thatcher suddenly made the following announcement in her written reply to a question on students' grants :

*As I announced on 6th May, the Government will make available the sum of £76 million for the improvement of student grants over the triennium 1971-74. After full discussions with the local authority associations of England and Wales, the Committee of Vice-Chancellors and Student Unions in accordance with the agreed procedure, my Right Hon. Friend, the Secretary of State for Scotland, and I have decided to increase grants for students on first degree and comparable courses as follows:—

(1)	Current Rates	1971-72	1972-73	1973-74
London and the Universities of Oxford and Cambridge	£420	£465	£480	£500
Elsewhere	£380	£430	£445	£465
At home	£305	£345	£355	£370
College of Education students in residence	£170	£190	£200	£210

(2) The starting point on the income scale for parental contributions will be raised from £900 to £1,100, and contributions will be reduced by £10 up to residual income of £1,699.

(3) With effect from September, 1971, equipment grants for medical, dental and veterinary students will be increased by one-third; similar grants up to a maximum of £20 will be paid to students of architecture and ophthalmic optics.

(4) A higher rate of grant for extra study will be paid to students at institutions in London than to those elsewhere.

(5) Other supplementary grants will be increased to the levels suggested by the Working Group which carried out the first stage of the review.

(6) In addition, minor changes will be made in the method of assessing some grants which will benefit certain groups of students.

Nos. 1 and 2 obviously apply to all students, and No. 3 specifically to us, although whether this is adequate is debatable. No. 4 applies to us, and in that we are a London School we will receive an increase in the £7 per week clinical grant, however, it is not actually stated that the £7 per week will be increased. Nos. 5 and 6 are very non-commital and may or may not apply to us.

To date, no detailed information on the points outlined above are available.

If, after clarification of these points, clinical students *continue* to be worse off than their non-clinical counterparts, I understand it is still possible for Mrs. Tatcher to add to these proposals, so that with a concerted effort we may still be able to obtain a fair deal for clinical students.

Lynn Hampson

*From Hansard Vol. 817, No. 147, 21.5.71.

MEMORIAL SERVICE

The Memorial Service for Sir Heneage Ogilvie, K.B.E., M.Ch., F.R.C.S., will be held in Guy's Hospital Chapel on Monday, 7th June, 1971, at 12.30 p.m.

GUY'S DIARY

JUNE

7	M	1.00 Clinical Lecture. Mr. MORRIS. "Liquor."
8	Tu	1.00 Clinical Lecture. Mr. LAURENCE. "Surgery in the Treatment of Rheumatoid Arthritis."
11	F	2.15 Combined Round. "The Ischaemic Limb." There will be three speakers: Mr. F. G. ELLIS (Guy's): "The Clinical Aspects." Mr. J. DORMANDY (Royal Free): "The Significance of Blood Viscosity." Mr. R. GREENHALGH (Essex County): "The Significance of Serum Lipoprotein."
14	M	1.00 Clinical Lecture. Mr. KINDER. "Carcinoma of the Prostate."
15	Tu	1.00 Clinical Lecture. Professor SIR HEDLEY ATKINS. "Jaundice."
18	F	1.00 Clinical Lecture. Dr. HYAMS. "Special Aspects of Geriatric Medicine." 2.15 Combined Round. Professor TROUNCE and his firm will present the round.

Our Glittering Tower

In the fields on the farms of Bermondsey
Once there was fruit and fine corn,
On the land round the thatched home dwellings
Flowers grew up from each lawn.
Each copse that sheltered the landscape
Was a shrine for the birds and the deer,
So over the greens to the river's edge
The throb of sweet song you could hear.
Old bridge 'cross the water, a gate to the south
Wrapped still when night's curfew falls.
Peeping lights from the quay sparkle upon the waves
With low murmers the plaintive gull calls.

Dirt grows on the concrete of Bermondsey
Filled with fumes are our plain brick homes,
Dull with soot are the small streets between them
Where the thundering lorry drones.
Here bawdy children scream strings of abuse
Their parents don't mind, so it seems,
While muting pigeons spoil sill and ledge
And dogs desecrate all the greens.
Under the shuddering bridge at night
Lapped shores are cloyed with thick fetid black,
No sound save the splash of self-ended despair,
With oiled plastic cartons, a life's given back.

Something's new in the sky of Bermondsey
And the council are ploughing below,
Up there through the thin air you'll probably see
The furrows of change in a row.
New houses, new people, a busy quayside,
A new bridge to join up the plain,
Yet the voice of tottering humanity calls,
"The slums in the back streets remain".
Is there hope in our high reaching monument
Overlooking the smell and the grime,
Or just a glittering Tower of Babel
Reflecting the sins of the time.

N. S. McLeod

A plain man's guide on how to fail Pathology

C. W. M. Adams

Among nearly all London medical schools the failure rate in pathology is higher than in medicine, surgery and obstetrics. Yet I am forced to the conclusion that many Guy's students regard pathology as a relatively unimportant hurdle. Furthermore, the view is promulgated that there is no pathology teaching at Guy's; even staff wives have heard from disappointed parents that we do not or cannot teach pathology. The truth is far from this. About 138 lectures and 40 tutorials are given to each student by the Division of Pathology. In addition, 70 histopathology demonstration-seminars are provided on Wednesday afternoons during the first two clinical years, and some 20 demonstrations are set out in the Department of Haematology during this period. To this mounting total can be added the 1,000 post-mortem demonstrations by the Departments of Pathology and Forensic Medicine, to which all students can expose themselves over a two-year period. The grand total is a staggering 1,266 sessions in two years. What now about no pathology teaching at Guy's? Perhaps there is too much. Perhaps we could lower our sights and suggest that students should come to a necropsy once a week and attend the Wednesday afternoon demonstrations for only six months. This more realistic demand provides over 300 teaching sessions for each student. Frankly, it is inconceivable that this is inadequate.

Why is it then that our pass-rate in the London M.B. pathology is declining? Perhaps the teachers are bad. Circumspect comparisons with other schools suggest that the Guy's teachers are on average at least as good as elsewhere. The Westminster School, however, is outstanding; it has some exceedingly able teachers and a *small student intake*. The rapport obtained in small medical schools seems to be a major advantage to students in contrast with the Todd-style unhappy image of sausage-machine institutions.

Over the last ten years at Guy's the structure, clarity and relevance of pathology teaching have improved or, at least, have kept abreast of the changing approach to pathology. Likewise, the volume of relevant teaching (apart from autopsies) has nearly doubled, or trebled if the newly-introduced pathology B.Sc. is taken into account. However, there is no room for complacency in teaching, which should be continuously scrutinized for defects. Informed criticism by students or recent graduates is always particularly useful to us in this respect.

Perhaps some students do not know what pathology teaching is available to them, yet it is posted in the pathology classroom and details can always be obtained from the school office. A hand-out about pathology teaching has been distributed at the end of the

Introductory Course for some years. Some students apparently miss, lose or forget it. Nevertheless, it is utterly incredible that they cannot inform themselves from other sources.

Perhaps teaching in pathology is given at the wrong time. There is more than a little justice in this comment. Undoubtedly, the Introductory Course could again be pruned and the saving in time used later. The impact of the Special Pathology lectures probably gets lost when spread out as a weekly event over two years. Plans are in hand to shorten the Introductory Course and condense Special Pathology lectures into a more compact course in the next academic year (1971-72). When the new M.B., B.S. regulations are introduced, we hope to provide a three-month pathology course close to the examination (the new Part IV) early in the second clinical year. Nevertheless, even though the present timing is faulty, this is no reason to pretend the teaching does not exist, nor to boycott it.

Perhaps other duties prevent students from attending pathology lectures and post-mortems. If so, they should make a point of asking for leave to attend scheduled school teaching. There is absolutely no virtue in testing normal urines in preference to attending a pathology lecture on renal disease. The irony of the situation is that, despite all this early morning paddling in the sluice-room, about half of the urines tested at Brunswick Square are partly misreported. I am sure that the senior medical and surgical staff at Guy's would be horrified to hear that some students have come to regard urine-tests, venepuncture and the like as more important than the 9 o'clock Special Pathology lectures. As pathology is the biggest stumbling-block in the final M.B., students should exercise their commonsense and get their priorities clear. To those of us who were not educated at Guy's this misreading of priorities would be a Gilbertian farce if it were not so serious. Turning to post-mortem demonstrations, the population-density in the park at lunch-time on a warm summer's day does not encourage me to think that students' time is too limited to attend them.

Perhaps it is thought that the whole of pathology can be entirely learnt on an *ad hoc* basis in the wards. This is an absolute misconception and is on the direct route to fail the pathology exam. The principles of pathology have to be learnt on a systematic basis in lectures and from books not in disconnected dribs-and-drabs. Informed opinion at other schools suggests that CPC's and such like are not very helpful until students are reasonably versed in the grammar of pathology. After this grounding, integrated teaching can indeed be very valuable. To benefit from such teaching and to be attuned to short ward-discussions on pathology, students must read the grammar of pathology in the early part of the clinical course as well as before their examination. Nevertheless, even the grammar of pathology is not best learnt in a clinical vacuum, so there must be some topic integration between pathology and its clinical application at an elementary level from an early stage.

Perhaps students do not concentrate on the right things. It is much more important in their early clinical years to find out what causes diarrhoea than to be caught up in an erudite CPC on von Willebrand's disease. Pre-occupation with the rarities, obscurities and irrelevancies at the expense of the commonplace and commonsense is a certain way to fail. Nobody fails because he has not heard of von Willebrand or does not know that the chains of Bence-Jones proteose are too light to tinkle in the pot; it very definitely helps to know the genetics of haemophilia and the general pathology of multiple myelomatosis; but ignorance about diarrhoea means a return visit to the examination hall. Where elementary integration really comes in is, for example, to know the clinical presentation and relative frequency of the irritable colon syndrome, ulcerative colitis, staphylococcal enterotoxin and *Shigella sonnei* as cause of diarrhoea. Where is it not safe to eat cream-buns or dubiously-washed salads and why? Is typhoid the same thing as bacillary dysentery? If not, what is the difference in their cause and clinical course? On a world-wide basis, typhoid, malaria, cholera, diphtheria, smallpox, plague and rabies are more important problems than liver transplants. Pathologists feel that students should have some knowledge of diseases that can become epidemic disasters and ask some questions accordingly. None of us would feel that the wards of Guy's Hospital are suitable places for the *ad hoc* teaching of the pathology of these conditions.

Perhaps students misunderstand the nature of the London pathology final. The four essay-type questions require all-round knowledge, as does the wide-ranging but superficial MCQ paper. Guy's provides practice pathology MCQ's at the end of the Introductory Course and at about a month before each London MB examination. The practical tends to be passive in the sense that candidates do not now have to stain organisms and sections, but they do have to test urine accurately. If the viva is straightforward the prognosis is good; if it appears to become somewhat erudite perhaps the candidate is being considered for honours; if it consists of continuous prolonged discussion of absolutely basic fundamentals the outlook is distinctly uncertain. A *short*, easy viva could well imply "OK, but please get out before you put your foot in it." In a *prolonged* viva at low level the examiners are usually exploring if they can possibly manage to push the candidate through. All of us have our weaknesses. If your Achilles' heel is pathology, be very certain of the simple things : ignorance of them is a well-tested recipe for failure. The stages of acute inflammation, the basic features of malignant neoplasia, the behaviour of bronchial and other common carcinomas, berry aneurysm, appendicitis, pneumonias, anaemias, thrombosis, liver-function tests, etc., streptococci, salmonella, smallpox, tuberculosis, inoculations, the major types of immunological reactions and commonsense are a representative collection of examination shibboleths. The Cambridge examination is not very different from that at London, except that there is no MCQ paper, there are more essay-type questions and candidates are expected to stain

bacteria and blood-films. Agglutination reactions sometimes appear in the practical, so revision should include perusal of your practical notebook from pathology in Part I of the Tripos.

Continuing this analysis of why students fail pathology, perhaps the real reason is *laissez-faire* or even frank disinterest. The theoretical audience at our Special Pathology lectures is 200, but the norm is only 50. It follows that these lectures are only 25 per cent effective in reaching the ears of the student body. How many students work through standard textbooks of general pathology, microbiology, chemical pathology and haematology? How many elect for the softer option of Walter and Israel? How many rely on the inaccurate lists in a certain short but often misleading slender volume? (I hope the editor knows the law of libel.) How many set themselves a target of 50 pages of pathology to read and re-read per week throughout the clinical period or, lacking such virtuosity, how many try a crash course of 40 pages a day for two months? How many students check on *relevant* recent advances by perusing leading articles in the *Lancet*? Even more to the point, how many check over the commonplaces to make sure they know the simple things? How many go through the last ten years' papers to plot out what sort of questions might be asked? My contemporaries at the London who neglected this simple precaution were regarded as either arrogant or just plain stupid. How many leave revision to the last two weeks? Education in pathology is not synonymous with last-minute frenzied requests for intravenous transfusion of information from certain good-natured, long-suffering members of the pathology staff. On a personal level, I thought it very odd indeed when half my tutorial group recently failed to turn up on a Friday afternoon: the next time we meet might be across an examination table in the not-so-distant future. It was equally odd a few days ago to find only two candidates for the autumn M.B. pathology in the post-mortem room when a standard examination question—berry aneurysm—was being demonstrated. Leaving examinations aside, surely the causes of intracranial haemorrhage are a fit topic for future doctors to see and discuss.

All this leads me to think that the fundamental fault is mine in that pathologists are too soft. Perhaps it is now time to crack the academic whip. We shall have to consider introducing grades and sign-ups for post-mortems and, henceforth, we shall absolutely insist on a certain minimum performance in our MCQ exams. It is a sad day for a professor when he realises that he has become a schoolmaster, and an equally sad day for those students who enjoy their pathology.

ADDENDUM

This article was written before Mr. C. J. Bennett's letter appeared in the *Gazette* (21st May, p. 261). I have four further comments to make:—

1. I am horrified to hear that ward duties seem to be given positive preference over scheduled systematic school teaching in path-

ology. This surely is not the wish of the consultant staff at Guy's. Who is it then who determines this priority?

2. The pass-rate in the last London M.B. Pathology examination was indeed only 43 per cent overall, being 57 per cent for those taking it the first time and 25 per cent for those taking it for the second (or more) occasion.

3. Qualifying with conjoint and taking a house-job may be an excellent preparation for re-sitting medicine, surgery or obstretrics in the London M.B., but is courting disaster for re-taking pathology. The inference is clear:—pass Part 1 of the final M.B. before taking a house job.

4. Mr. Bennett's letter and these further remarks do not alter two major reasons for failing pathology :—not enough reading and not following cases to necropsy.

BOOK REVIEWS

PRINCIPLES OF CLINICAL ELECTROCARDIOGRAPHY,

7th Edition. 400 pp. £3.35. Mervin J. Goldman.

In this 7th edition the author has expanded the sections on electrophysiology electrical depolarization of the heart and intraventricular conduction defects. However, this edition remains little different from the 6th.

It is an excellent paper-backed book, covering the whole field of electrocardiography, in reasonable depth. There is an emphasis that the electrocardiogram should only be interpreted in the light of clinical findings, which I find very welcome.

The illustrations are clearly reproduced and the diagrams are well drawn. I don't think it is a book that medical students should necessarily buy, but would consider that it would be an excellent reference book.

D. C. FLUCK.

ELEMENTS OF MEDICAL STATISTICS

Staples Press. J. V. Smart, Statistician, Smith, Kime and French Laboratories Ltd. 176 pp. £2.50.

There are too many textbooks of statistics in existence, most of them cover much the same subject material, and much of this is irrelevant both to the practitioner and reader of clinical trials. The proliferation of books is not difficult to account for—the choice of a text in another subject inasmuch a matter of personal idosyncrasy as choice of a marriage partner, but the contents often seem deliberately chosen to encourage readers to ask useless questions, and the number of valuable Statistics books is therefore rather small.

Mr. Smart's book is conventional in its subject matter and approach, and as a statement of the usual topics, it is good of its kind and very readable. The book suffers from what appears to be an attempt at economy by the publisher; the layout of some formulae is so bad as to be positively misleading; this is of little consequence, as they are of no use to the reader anyway. A more serious flaw is the presence of a few technical errors in the text, including an unfortunately shaky version of the old faithful "t-test".

A real clinical trial should be analysed by a competent statistician, and the objective of this book must therefore be to use particular techniques as illustrations to improve the readers' understanding of the aims of analysis. In this success is only achieved in a few topics, and many considerations which are more important in clinical trials than the mere arithmetic are ignored entirely.

FRANK HOUSE.

Preventive Medicine in the Himalayan Foothills

P. Powell-Jackson

As students from Guy's, two of us recently had the opportunity of spending a few months in Nepal. We were working for an organisation called the Britain-Nepal Medical Trust (B.N.M.T.), which by receiving charitable support from Britain is able to assist the Government of Nepal mainly in the field of preventive medicine.

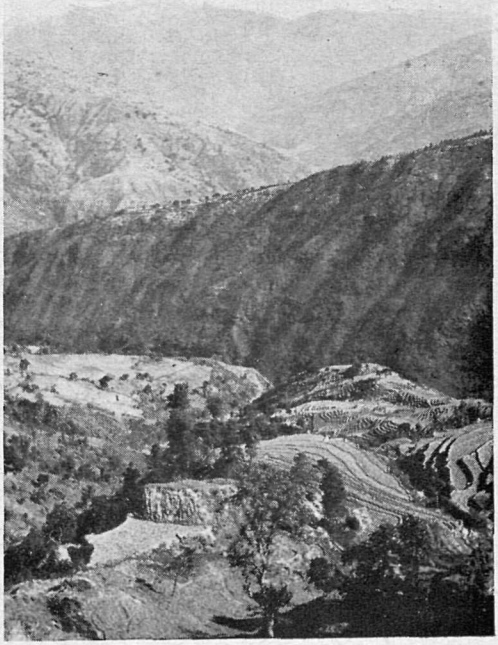
All developing countries are a challenge but for a number of reasons Nepal is special. The country is bounded to the north by Tibet and by India to the south but, unlike them, it has never been colonised. Nepal has always kept her political independence and has voluntarily maintained her own isolation, even in the days of the British Raj. As the Indian Empire became more developed Nepal by comparison remained medieval. Twenty years ago the present king replaced what had previously been a succession of corrupt régimes, none of which had made any effort to improve the welfare of the people. Today Nepal is more outward looking and skilfully walks a political tightrope by accepting generous aid from such countries as China, U.S.A., U.S.S.R., and India, all of which, no doubt, having their own political axes to grind.

In a sense, Nepal has been left behind by the rest of the world but is now trying very hard to catch up. Without foreign aid this would be impossible because there is practically no industry and very little exploitation of natural resources. Most of the eleven million Nepalese are peasants only able to scratch a living by means of subsistence farming. Very few of them have had any school education, resulting in the high illiteracy rate of 90 per cent. The challenging work of improving public health is therefore hindered by a general lack of knowledge concerning the basic principles of hygiene. A few examples may help to clarify the position. One of the more popular national pastimes is spitting, an unhealthy habit since some of the worst offenders are sufferers from tuberculosis. Effective sewage disposal is unknown even in the towns. Flies and starving dogs ensure rapid dissemination of disease. Furthermore, there is no understanding of the reason for washing hands before meals, the washing of plates and glasses, or the proper cooking of food and heating of milk before use.

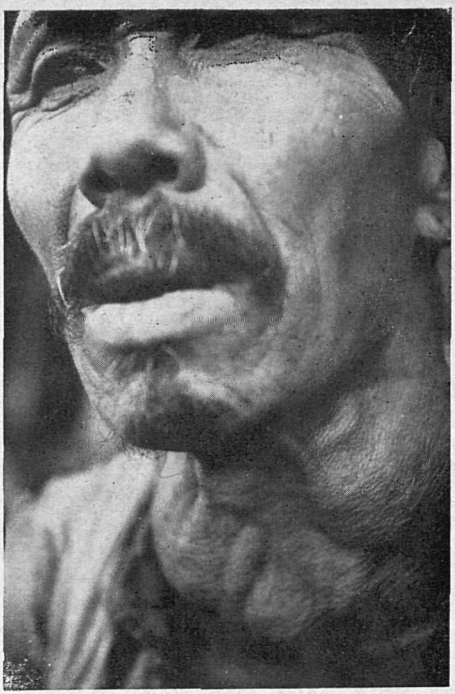
Opportunities for higher education are very poor. The few wealthy people send their sons to school and university in India. Nepal has no medical school but one hospital in Kathmandu does train nurses. Doctors returning to Nepal are attracted to the capital where there are both favourable medical facilities and wealthy patients. The country areas are therefore neglected.

Aware of the poor medical services outside Kathmandu, the B.N.M.T. has concerned itself with preventive medicine in the eastern

part of the country and with the setting up of an efficient government hospital in that area. The foothills of the Himalayas present certain difficulties in communication. There are no roads, no navigable rivers, no telephones and few areas flat enough for an airstrip. Everything has to be carried on men's backs since the hills are too steep for pack animals. Towns are small and separated by deep valleys from one another. It may take a few days to walk from one town to the next. It is therefore difficult for the doctor to contact the patients in his area. Furthermore, the setting up of clinics and small hospitals and supplying them with drugs and equipment is not only slow and difficult but also expensive. Similarly, surveys and vaccination programmes require a considerable amount of organisation and a vast expenditure of time and effort. As in all developing countries the medical priority is in the field of preventing infectious diseases. The main problem at present is the eradication of tuberculosis, smallpox, undifferentiated gastro-enteritis, leprosy, malaria and goitre. So far malaria has been eradicated, by D.D.T. spraying, from those areas in which, ten years ago, it was endemic. At the moment the Government is considering a nation-wide B.C.G. campaign involving the B.N.M.T. To avoid wasting time and effort, this should be combined at the same time with a smallpox vaccination programme, an ideal that in the past has been difficult to achieve. Goitre is endemic, resulting in a high incidence in children of cretinism and deaf mutism. The goitre is primarily due to a lack of iodine in the drinking water. Some water supplies to the few large towns can be iodised.



"Communication in the hills of East Nepal are made difficult by the rugged terrain."



"In the worst areas of iodine deficiency nearly all adults develop goitre. This large nodular goitre is causing engorgement of the neck veins."

However, outside the towns the water supply is usually a running stream and alternative methods have to be employed. Iodised salt is difficult to supply to the remoter areas and also it tends to deteriorate with storage. Other techniques such as depot iodinisation of well water and the expensive intradermal deposition of idoine are being tried.

A W.H.O. survey showed that 12 per cent of the population had smallpox scarring. The mortality from the disease was known to average 30 per cent so it was apparent that smallpox affected actively at least 16 per cent of the total population during their lifetime, or about $1\frac{1}{2}$ million persons. In the past it was customary for native doctors to practise variolation or the vaccination of uninfected persons with the fluid retrieved from the pustules of smallpox. In many areas this variolation formed part of a religious act. It was associated with a degree of morbidity and mortality from the resultant active disease. Cowpox variolation was also probably practised. Variolation is now forbidden by law. It is hoped that the whole country will be vaccinated by 1973 and smallpox eradicated by 1977. It is then anticipated that the basic health services will undertake the routine vaccination and revaccination of the population.

The incidence of leprosy is $\frac{1}{2}$—1 per cent. The disease still carries a stigma and in some cases an attitude of fear and hopelessness. In certain rural areas leprosy patients are still not allowed to return to their villages. At present very little can be done to help the large numbers of patients involved. Future progress will have to be aimed at the education of children.

One of the main lessons to be learnt about medicine in a developing country is that it is absolutely vital that all available resources should be channelled into the fields of preventive medicine and basic public health education rather than into the setting up of relatively sophisticated hospitals which, although coping with isolated medical and surgical cases, have relatively little effect on the health of the whole community in the long term. For instance, in the field of tuberculosis, the first priority should be the inoculation of the country's children. Then follows the expensive, prolonged and often unsuccessful treatment of the estimated 100,000 sufferers from the disease. Although the inoculation of children in the schools and villages is a time-consuming and difficult task, it is not an expensive one. It is quite possible for one doctor to inoculate a thousand

"Tuberculosis often gives rise to skin signs as in this case of scrofuloderma due to infection of the lymph nodes in the neck."

children in one week for less than it costs to cure one adult case of tuberculosis. A BCG campaign must of course be backed up eventually (when resources permit) by a system of TB clinics situated in the main centres of population and specialising in diagnosis from the history, physical signs and sputum examination only.

At present there is only one clinic in the hills of east Nepal. Patients have been known to walk for eight days to reach it. Those who are most seriously ill may have to stay for two months or more. This represents a great strain on their finances because most have no savings and are so poor that they cannot afford to leave their land for so long. Unfortunately, the B.N.M.T. cannot afford to feed the

patients in addition to supplying them with medical care. Ironically, this is just the type of patient who requires a good diet, since all are anaemic (some have a haemaglobin as low as 30 per cent) and severely malnourished.

The B.N.M.T. has been in Nepal for only four years. During that period there have been times of deep frustration; moments of reward, such as the planning and setting up of TB clinics in isolated towns; and moments of challenge, such as the government request for a B.N.M.T. organised BCG/smallpox vaccination programme for the whole country. The B.N.M.T. welcomes visits from students as it is keen to recruit suitable nurses and doctors. It is an opportunity that is both demanding and yet offers great rewards.

NURSING SECTION

Nursing— a Profession

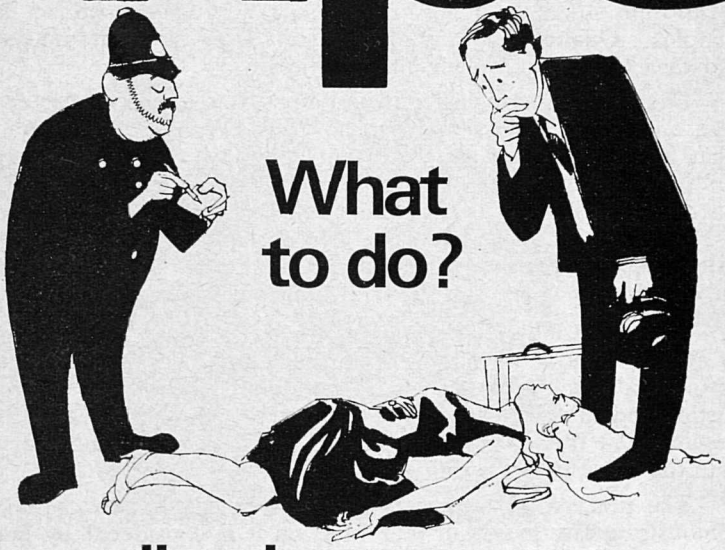
In this country, nurses are usually regarded by the general public very favourably. Sympathy has always been strongly directed in the interest of their causes, thus creating a pleasant state of affairs. However, one is frequently given cause to wonder whether the image is merely that a group of very kind young girls, any of which one would like for a daughter, who voluntarily undertake tasks which to many would be most distasteful, or if it is that of a true "Profession", comparable with medicine or law. Unfortunately, one is led to the impression that the former is the case.

It might be worth considering whether or not nurses may rightfully claim to be a professional body or not, since doubt arises.

The Oxford Dictionary defines a profession as a "vocation or calling especially of a learned, scientific or artistic kind". In order, therefore, to effect a comparison one must first establish the conditions of entry and practice of such an occupation in normal instances.

Initially, the aspiring applicant must have attained an acceptable standard of general education. Should he fail in this respect it will be pointless for him to attempt to cross the threshold. However, in the event of him being accepted as a student he embarks upon a predetermined period of apprenticeship. This will terminate upon the successful completion of examinations devised by the Professional Body concerned. These are normally of a high standard. He will then make application—usually by payment of a fee—to have his name entered upon the register of qualified practitioners. Thereafter, he is free to pursue his chosen work provided he does not exceed the bounds set by the professional code. Should he be foolish enough to do so, he will be reprimanded by his Professional Body, and if necessary by the legal system. The result of the former will probably

mps



medical protection society est 1892

Unlimited legal aid
and indemnity against
professional hazards
throughout the world
(except U.S.A.)

Secretary Dr. H. A. Constable. Head Office
50 Hallam Street, London, W1N 6DE. Tel: 01-580 9241
or Regional Secretary Dr. P. G. T. Ford
Regional Office: 30 Park Square, Leeds 1. Tel: 0532 42115-6

be to have his name deleted from the register, thus making it illegal for him to continue practising. Provided, however, that he does not exceed the stipulated boundaries, there is available to him, considerable freedom. Financial reward will come either from a salary, or by the charging of fees to clients or by a mixture of both. Throughout his career he is expected to continue his learning either by reading or sabbatical leave as the public expect a definite standard. Normally, this person is considered by society to be one of authority and integrity.

Let us now compare this situation with that of a nurse. Firstly, there is no definite standard of entry, and during the period of apprenticeship the student forms part of the main working force. She is, in fact, used as cheap labour—whether or not she should become a full-time student cannot be discussed here as the subject is too complex. Qualification and registration follow the aforesaid pattern, and then the picture again alters radically.

Firstly, the nurse has imposed upon her a much stricter code than any other professional person. She even has dictated to her what her attire will be to the extent of the way she wears her hair, and dons her make-up. Except in a few notable instances such as a District Midwife, she is given no professional authority whatsoever. If she expresses an opinion she is reprimanded, if she states it in writing there is danger of dismissal! She may not supply a reference for a colleague unless the status of matron has been achieved.

The nurse may charge no fees for her services, and is expected to accept without complaint a meagre salary, despite the fact that her clinical responsibilities are of the highest order. For all this she is supposed in some strange way to remain eternally grateful to the hospital that trained her, although she may have returned far more than the value of her training.

The nurse is not expected to be learned. In fact, should she demonstrate any moves in this direction it is considered by her colleagues to be bizarre almost to the point of verging on abnormal. Even if she attempts to improve her general knowledge, by perusal of educational literature, disclosure of the fact is not advisable! In view of this, nurses are noticeably inflexible in their views, and the high female content leads to much feline behaviour. Lastly, the public do not receive a single standard of service.

Bearing all this in mind, is it not time that the Profession took a lengthy objective look at itself? How can it expect to attract women and men of intelligence and integrity to such conditions? They cannot call them Professionals and treat them as skilled labourers. Nursing as a career, has had respectability now for a century. Should it not have reached maturity at a hundred years of age?

If nursing does not give to its licensees the authority to practise their careers in the same way as other professions, can it rightly use the name which it claims? One remains in doubt!

OBITUARY

FLORENCE TAYLOR, S.R.N., S.C.M., S.T.D., D.N.London

Florence Taylor, affectionately known by many Guy's men and women as "Sister Flo", died in Nuffield House on 23rd April, 1971. Miss Taylor began her training in the School of Nursing at Guy's Hospital in 1916, after previous experience in St. Mary's Hospital, Carshalton. She was outstanding in all the School internal examinations and qualified in 1919. Her training record notes that she was active, keenly intelligent, kind, and a meticulously carefuly practical nurse. She studied further and gained the Certificate of the Central Midwives' Board, the Incorporated Society of Trained Masseuses, and later the Diploma in Nursing of the University of London.

After working as a Sister in the Norfolk and Norwich Hospital, Florence Taylor returned to Guy's in 1925 as a night Sister, Office Sister and later, as a Tutor Sister, working with that notable Senior Tutor, the late Miss Hilda Gration and also with her colleague, Miss Dorothy Holland. They were a remarkable trio. Ultimately she became the Senior Tutor Sister. She was an inspired teacher, a

disciplinarian in the best sense of the word—she had a keen sense of humour and her kindness and encouragement of young nurses has been testified by many of her past pupils. Travel delighted her, both for professional business and for pleasure. She was a British delegate to the International Congress of Nurses in Canada and in the U.S.A. and to other professional bodies. In her car she extensively explored Europe.

Her death, on 23rd April, St. George's Day and Shakespeare's birthday, was a fitting anniversary date for her, who was a true patriot and loved her country, England. She wanted—as did St. George and Shakespeare—England to be a God-fearing nation, carrying the emblems of integrity, courage and gentleness on its shield. Florence Taylor herself was the epitome of these qualities. To her, right was right and wrong was wrong. Her warm strength of character gave strength to her friends.

Nothing daunted her. In war-time she and her little car skimmed through the Kentish lanes, sometimes showered by incendiaries and on one occasion overturned, but always reaching one of the six scattered units of the Guy's School of Nursing, giving a lecture or class, quietly and sympathetically listening to possible troubles or anxieties among her young student nurses, then skimming home again to talk things over with the Matron.

When peace came, she helped to bring together once more, to the parent hospital the six scattered units of the School and she inaugurated the scheme of the Block System of nurse training, to which much study had been done before the war by the three Guy's Tutor Sisters and others. It was the first scheme of its kind in Britain. Miss Taylor took a keen interest in nursing politics and, at one time, was chairman of the Tutor Section of the Royal College of Nursing.

After the war, in retirement in her home in Blackheath Park, where old Guy's nurses were warmly welcomed, she continued her close association with Guy's by becoming, for over ten years, Chairman of the Council of the Nurses' League (over 3,000 members) and for the last three years, until her death, as Vice-Chairman.

Flo Taylor loved a country life and country affairs. From time to time she visited me on my farm in the West of Ireland, and entered with high spirits and zest into the very rural life of the surrounding villages. On one occasion, the man who looked after my pigs bashfully reported that their "nature" was out of order, and that his medicine had proved of no avail. Flo immediately stepped into the breach and I have a snapshot of her clad in a mackintosh apron, merrily speeding down the bog lane to the pigsties, carrying a big can of solution and the necessary tackle. The result was excellent.

Dear Flo. In the past few years she had various troublesome periods of ill-health but nothing could break her spirit, her gay outlook on life and her trust in God. She did not wish us to mourn for

her and therefore we thank God for her life and all that she meant to Guy's—and to us.

In Browning's words :

"One who never turned his back but marched breast forward
Never doubted clouds would break,
Never dreamed though right were wrested wrong would triumph.
Hold we fall to rise, are baffled to fight better,
Sleep to wake."

E. MacManus.

NOTICES

MUSIC CLUB

Concert Calendar, 1971

The following list is of concerts and recitals which the Music Club plans to produce during the coming year. It is intended as a rough indication only and any events may be subject to alteration at a later date.

June 9th—Concert of various items in Wandsworth Prison.

June 17th—Concert of Indian Sitar music to be performed by Mr. Manesh Chandra, at 8.0 p.m. in the North Common Room.

July 15th—Recital by Guy's students. To take place in the North Common Room.

August 12th—Open-air concert in the Park (weather permitting!).

September 9th—Open-air concert or another recital.

October 14th or 21st—Freshers' recital, taking place in the North Common Room.

The success, or otherwise, of most of these events depends not only upon our ability to attract an audience but on the availability of artists willing to come forward and participate. In the past, these events have been extremely successful but have depended largely upon the enthusiasm of students in their final years of study. Support from the more junior students at Guy's has, unfortunately, been difficult to enlist. This is a state of affairs which the Club is trying very hard to abolish.

Phys Williams (Hon. Secretary)

GUY'S CHRISTIAN DISCUSSION GROUP

Invite you to

A series of Informal Discussions on the

"Insights to the Book of Revelation",

led by the Rev. Roger Royle
(Southwark Cathedral)

from 13th May to 17th June, 1971.

Meetings are held each Thursday
in Classroom 1a, Medical School,

from 1.00—1.45 p.m.

EVERYONE IS WELCOME

CORRESPONDENCE

Paternity Testing

SIR,—It may not have been apparent to many readers of the article of "Paternity Testing at Guy's" in the current number of the *Gazette*, that this new and effective scientific contribution to the age-old legal wrangle on whose child this is, has developed almost entirely in Guy's under the guidance of Dr. Alan Grant, Lecturer in Serology in this Department.

Guy's is curiously reticent to admit its successes in making outstanding advances in the fields of science, and so long as able "back-room boys" are content to remain anonymous, the reputation of this school will remain on the ground floor. Some fine work is being done and the *Gazette* should be proud to indicate that it is being done by Guy's men—of whom the author of your article "I. D. Bradbrook" is one.

I am, etc.,

KEITH SIMPSON.

Department of Forensic Medicine,
Guy's Hospital Medical School.

Some More On Salmon

SIR,—When I attended the annual general meeting of the Guy's Hospital Nurses' League a few days ago, I was very sorry to hear so much hostility expressed towards the proposed implementation of the Salmon Structure for senior nursing staff at Guy's. I do not pretend that this structure is perfect, nor will it solve all our problems, but I do believe from recent experience, that properly administered and understood, it does, after the initial upheaval of reorganisation, lead to better patient care and career prospects.

In any case, it *is* agreed national policy and sets out guiding lines within which each group of hospitals uses its own expertise and initiative. But it can only work successfully with full support and co-operation from nursing, medical and administrative staff, and I hope that League members will help all concerned in any way they can. Certainly to continue with a jaundiced view is no help to those who have the difficult task of implementing the structure.

Yours faithfully,

EVELYN A. OPIE.

63, Windrush Way,
Hythe,
Southampton SO4 6JF.

Bowen-Simpkinsberger

SIR,—Peter Bowen-Simpkins will not find me very tasty.

Yours ever,

ARNOLD SCHULTZBERGER.

East Wing,
Guy's Hospital.

Pathology Teaching ?

SIR,—It appeared to me to be rather anomalous to head Mr. Bennet's letter in the last edition of the *Gazette* "Pathology Teaching". It seems to me he is complaining about the general scheme of medical education as opposed to pathology in particular.

There are, however, a few important points in his letter which I should like to amplify. The problem, as I see it, is whether medical education should aim at getting the student through a series of examinations, or aim at pro-

AFTER GRADUATION... WHAT?

The newly qualified Dental Surgeon leaves hospital with a fund of professional knowledge but generally ill prepared for putting this to the practice of earning a living.

The first assistantship is of paramount importance, with special emphasis on working with a Principal who can provide the right professional guidance and bearing in mind such essential matters as surgery conditions, remuneration, location and partnership possibilities.

LOCUMS LTD. specialize in launching young graduates into professional practice. Assistance to thousands of Dental Surgeons has been our business for many years. So consult Our Registrar today for free, friendly and helpful guidance. Ring—Write or Call:

LOCUMS LTD.

30 THURLOE STREET, SOUTH KENSINGTON, LONDON, S.W.7. Tel. 589 7292 (5 lines)

ducing a better doctor. These two points are important, and it behoves every medical student to decide exactly what he thinks about this subject. In the long run it is the student who decides to a major extent what sort of education he wants, and gets; whether by not attending lectures that he considers, rightly or wrongly, to be dull, uninteresting, or unrelated to the practice of medicine, or by bringing his wishes to the attention of those in authority as Mr. Bennett has attempted to do.

It has been assumed in many university unions that the student knows best how he should be educated. In medicine, however, such an argument is difficult to apply, as knowledge gained during the clinical years has to be utilised immediately on qualifying, often in unforeseen circumstances. It is the very uncertainty of what may befall one that makes as wide an experience as possible, necessary, if not totally essential to a better practice of medicine.

To talk of a "year's release from formal firms" would seem to indicate that a third of clinical medical educational experience would be lost. I, for one, believe that such experience is the best way of learning, and any number of so-called revision tutorials would be useless unless the original knowledge has been gained in the clinical sphere.

I feel this is why pathology in particular is often lost on the student, in that it is not taught in a clinical environment in relation to patients with disease, but more often in a hot lecture theatre with reference to a pot totally divorced from the clinical situation. Let us hope that the proposed pathology firm will avoid this, and be integrally combined with clinical medicine and surgery.

As for revision tutorials, these are obviously useful in the immediate pre-examination period, but I am sure Mr. Bennett would agree that they could not be expected to be a substitute for knowledge gained by consistent work during the full three years of clinical study. Nothing can be created out of nothing.

I remain, sir, your servant in hope of a more sympathetic approach to medical education.

East Wing,
Guy's Hospital,
London, S.E.1.

Yours sincerely,
D. NICHOLAS BATEMAN.

The Will's Library

SIR,—The Dean and the Will's Library Committee are aware and regret that the Library has been passing through a difficult time since the resignation of Mr. Hill.

His successor, the new Will's Librarian, Miss J. M. Farmer, F.L.A., has been appointed by the School Authorities, and is to start in July. With her help I am confident that improvements will be introduced.

The Library Committee, which meets frequently, includes in its membership representatives of the Junior Staff. It always welcomes suggestions, and Professor Foxon (deputy honorary Will's Librarian) and I will be pleased to discuss Library matters with anyone wishing to do so.

Yours faithfully,

Guy's Hospital,
London, S.E.1.

REX LAWRIE
Honorary Will's Librarian.

Easter Concert

SIR,—I would like to congratulate Mr. Ian Starke on his playing of the Bach arrangement of Vivaldi's A minor Violin Concerto at the Easter concert, which he modestly omitted to mention in his review of the concert. The concerto has several passages which tax the performer to the full, especially some fast pedal-passages which are in no wise helped by the now obsolete straight pedal board of the Guy's Chapel organ. The limited range of tones on the instrument were well used, and it was a pleasure to listen to this competent performance.

East Wing,
Guy's Hospital,
London, S.E.1.

Yours sincerely,
MARTIN ST. G. WHEELEY.

SPORT

CRICKET

2ND XI

The second cricket eleven this year resembles closely the successful football team run by the Angels during the winter. This magnificent collection of all-round sportsmen have decided not to waste those months from May to September running to seed in the bar, but to turn their undoubted skills to the cricket field.

The first match of the season was against Stanstead Hall. The Angels batted first on a deceptive wicket, and had it not been for Simpson, who scored 55, they would have been routed. One cannot help thinking, however, that perhaps he would have served his side even better had he not run four of them out.

The Guy's bowling, too, was a little rusty, and Stanstead only lost three wickets in scoring the required 117 runs.

The following week the Angels played at H.O.P. against the Royal Dental Hospital. This time the Guy's side bowled first, and were soon on top. Rigg did particularly well by cleverly varying the speed, direction and pitch of each ball. One masterpiece of subtlety was a slow long-hop delivered from two paces behind the umpire: this somehow secured a wicket.

Having dismissed R.D.H. for only 90 runs, the Angels were confident of victory. However, when they lost three wickets for only ten runs, they were in trouble. Despite a spirited fight-back, they failed in their set task, never quite overcoming the danger of the slow straight one. P.J.S.

MATCH v. CARNEGIE

H.O.P. 8th May. Lost.

Carnegie batted first and some good bowling and fielding by Guy's ensured that they were dismissed for 125. This total would have been considerably less had their one player who scored any runs (53), been dismissed when he was 0 and dropped at leg-slip. However, he gave us a good display of how not to hit the ball along the ground! Guy's batting was sadly lethargic, but the main fault stemmed from the openers, who took a vast amount of time scoring very few runs. John Powell-Jackson batted well for 26, but Guy's were dismissed for 84 runs, which was all the more disappointing since we could so easily have won.

MATCH v. ASHSTEAD

Away. 9th May. Lost.

The Ashtead batsmen seemed to be very comfortable against the opening bowlers, when an inspired piece of captaincy brought on that old-stager, Mike Fordham, wearing white trousers for the first time since last July. The batsman, who had 40, was somewhat confused as the first ball went full toss to the wicket-keeper (standing a long way back)! He was even more bewildered as the next two balls passed very wide, one outside the leg stump the other outside the off stump (the umpire, in his wisdom, did not, in fact, deem these to be wides). The next ball, having bounced twice before it reached the unfortunate batsman's ankles, was dispatched into square leg's hands. The first over having been a wicket maiden, Fordham took a second wicket in his next over (a difficult catch, luckily held by a substitute). However, after an embarrassing third over, he was taken off to great applause! Ashtead were eventually all out for 200.

Guy's, unfortunately, had very few batsmen, with Goodhart, Gillham, Evans and Clifford-Jones all unavailable for one game. We were shot out for the embarrassingly low total of 47, with only Fitton and Langdon reaching double figures!

MATCH v. STOICS

H.O.P. 12th May. Won.

This is a somewhat debatable result. Stoics declared generously at 174 for 5. Holland was out early on, and Langdon, who had just begun to start

scoring freely, was needlessly run out for 23, but Evans and Goodhart batted very well, and the score coasted along towards the target. Evans made a good 56, and Goodhart and Ayres had to score four off the last over to win. Goodhart scored two off the first ball, but the score only moved to 172 on the board. He scored another two off the fifth ball, and according to our book, we had won, but the board showed our score at 174 for 5. Off the last ball of the over, Goodhart was caught (he scored 54), and according to Stoics, the result was a draw. Their score book was totally different to ours, which, after five recounts, showed that we had, in fact, won with the score at 175 for 4, with one ball left.

The following played in at least one of the matches: Goodhart, Langdon, Clifford-Jones, Gillham, Fordham, Rees, Davies, Evans, Ramsay, Burns, Das, Chegwidden, Holland, Powell-Jackson, Oram, O'Keefe, Hoyos, Ayres, Kelleher, Hanson.

CHRIS LANGDON.

BOAT CLUB

LADIES' BOAT CLUB

Guy's Ladies met with limited success when they entered a "coxed IV" in the Novice Class of the River Lea Regatta on 22nd May.

In spite of bi-weekly rowing and coaching sessions at Chiswick, which have taken place since Guy's Ladies' Boat Club came into existence last October—and valuable racing experience gained in their recent "bumps" début—the crew failed to crack the fierce female opposition, provided in the first heat by an experienced crew from Marianne Thornton School.

Guy's poor start gave Marianne Thornton a lead of one length—which they had doubled by the end of the 600m. course—although Guy's Ladies had "rowed hard" throughout to prevent the gap from widening further.

The result did not dishearten the crew, but has provided a stimulus to improve their technique, with a view to obtaining better results in future regattas.

Crew (see photograph): left to right—Stroke, Elizabeth Ryman; 2, Mary Wade; cox, Kathleen Spencer; bow, Margaret Walter; 3, Kathryn Marshall.

Medical Officers and Registrars

for Queensland, Australia

HOUSE OFFICERS

Salary $A5,646 p.a.

SENIOR HOUSE OFFICERS

Salary $A6,233 p.a. rising to $A6,823 (3rd year), $A7,532 (4th year).

REGISTRARS

Salary $A8,193 p.a. (1st year), $A8,529 (2nd year), $A8,863 (3rd year), $A9,197 (4th year).

The hospitals are all modern and have the finest equipment and resources available in the country. The number of beds ranges from 90 to 400, with an average of 250 per hospital. All have full-time supervisory staff and visiting consultants.

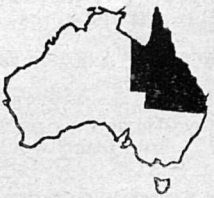
The Director General of Health and Medical Services will be conducting interviews in the U.K. until 7th July and will make immediate decisions on the appointment of applicants.

Please write, outlining your qualifications to :

The Medical Officer,
c/o Queensland Government Offices,
392 Strand, London, WC2R 0LZ.

---

about Queensland



Queensland, Australia's Sunshine State, is situated in the North-east of Australia. The climate varies from Mediterranean temperatures in the temperate southern zone to tropical summers and mild winters in the North. Sunshine throughout the country averages seven hours a day. Educational, housing and living conditions are extremely good and the standard of living is high. Many of the hospitals are situated within easy reach of the coast where boating, fishing and water ski-ing are enjoyed all the year round.

GENTLEMEN'S BOAT CLUB

RIVER LEA REGATTA—Restricted IV's

Heat—v. Globe B.C. Won easily.
Semi-final—v. Kensington B.C. Won 1½ lengths.
Final—v. Berkhampstead B.C. Won 3 lengths.
Crew: Bow, C. J. L. Price; 2, P. Stevenson-Moore; 3, R. Pinkney; stroke, M. J. Gleeson; cox, F. Moorhouse.

HAMMERSMITH REGATTA—Junior-Senior Coxless IV's

Heat—v. Thames Tradesmen: disqualified for clashing.
Having lost one length on the start, the crew were just about to row through the opposition when rounding the final bend, and because of a severe cross-wind, did just that!—the umpire had no other option but to disqualify the Guy's crew.
Crew: Bow, M. J. Gleeson; 2, P. Stevenson-Moore; 3, R. Pinkney; 4, stroke, J. C. Miller.

BARNES AND MORTLAKE REGATTA—Coxed Restricted IV's.

Heat: beat Quintin, 4 lengths. Lost to Kensington, 1 length.
A very poor, unco-ordinated performance due mainly to lack of practise together as a crew and a hurried journey to the start.
Crew: Bow, G. Moulding; 2, P. Stevenson-Moore; 3, R. Pinkney; stroke, M. J. Gleeson; cox, F. Moorhouse.

SOCCER

GOVERNOR'S SHIELD

Second leg match played on 25th April, 1971.
Guy's Staff XI 8, Students' XI 1.

The Staff XI went into this match with a two-goal deficit, having lost the first leg in the autumn 2—4. However, it was clear from the pattern of play in the first quarter of this match that the overall result would never be in doubt, and the final score-line did not exaggerate the difference between the sides. To say that the students were lacking in skill and ideas is to be polite, but their lack of stamina deserves criticism.

It is difficult to assess how good the staff side were in overwhelming the opposition since a team only plays as well as it is allowed to play. Suffice it to say that the basic skill of many of the players was good enough for them to be recognisable as real footballers and the whole side used the ball as a team should.

This match should be recorded in the *Gazette* because it gave satisfaction to some of the old men in the Staff XI, who would like to remember it. The Students' XI would doubtless prefer to forget it.

Teams: Staff XI.: R. Harper, K. Taylor, W. Binnie, M. Taylor, B. Nelson, P. Hennersey, D. Packer, D. Lindridge, L. Evans, B. Leahy, A. Bush, Sub., A. Smith.

Students' XI: R. Walsh (R. Lewes, sub.), M. Drew, J. Andre, E. Edwards, A. Godman, A. Hall, P. Glenn, P. Coley, D. Arnold, J. Ramsey, B. Armstrong.

Goals: Staff—Evans (3), Leahy (2), Lindridge (2), Hennersey. Students—Armstrong.

Both teams would like to thank Mr. D. Green for his excellent refereeing.

SAILING CLUB

GUY'S SAILING CLUB—FACT OR FICTION?

Most people, when asked about the existence of the Sailing Club, would probably have heard of it—but little more. Further investigation would reveal that it consisted of a smallish group of peope who raced mostly in the winter months on reservoirs and inland waters. Newcomers who did not understand the complications of team-racing would have to be keen indeed to withstand the winter weather without the protective clothing which is probably only owned by the already initiated.

MR. GUY'S HOSPITAL

In 1954, "Mr. Guy's Hospital" was published. This book was sponsored by the Board of Governors and written by Dr. Hector Cameron, a former Dean of the Medical School and Children's Physician, who retired from the active staff in 1945 and spent his later years as a writer of no little merit.

The book, when it was published, was regarded as an authoritative, well-balanced account of the life of Guy himself and of the history of the Hospital which he founded as well as of its Medical and Dental Schools. It took into account a wealth of original material which had not been available to the earlier standard history by Wilks and Bettany, and is an indispensable background to those who have a real interest in the beginnings and history of this institution. It is attractively printed and liberally illustrated with a number of plates.

This book is no longer available through the normal trade channels, but a number of copies are still held by the Hospital. These are available for sale from **The Cashier, Counting House, Guy's Hospital, London, S.E.1,** price £1.15 (including 25p packing and postage)—cash with order, please) or 90p on personal application. Any readers of the "Gazette" who are interested in obtaining a copy, are urged to make application as soon as possible to avoid disappointment.

With the advent of summer, these disadvantages disappear, and there should be plenty of opportunities for others to take up the sport, whether it be to race or just sail along following the beer cans trailing in the wakes of the boats ahead! However, at the moment, nothing much of this sort takes place, as those of us who can sail usually go our own way in the summer.

The club only owns three boats—two Firefly's, which are kept on the Welsh Harp Reservoirs (next to the North Circular Road), and an Enterprise, which is kept at Burnham-on-Crouch (down the Thames, turn left and it is the first estuary on the left!). However, there are 40 or so other college boats at the Harp which can be borrowed, and in addition, membership of the United Hospitals' Sailing Club enables members to use the sleeping and eating facilities of the Burnham club-house and the use of two Squib keel-boats and another Enterprise. The Welsh Harp is an ideal place to learn the basics of sailing with the advantage of not having to travel far to get there, whilst the attraction of Burnham is that a week-end spent there not only gets one "out of London", but it is a very pleasant social occasion.

So, the facilities are there—and now it is up to people to use them! It has been suggested that we run a teaching session at the Welsh Harp one evening a week and longer trips to Burnham at week-ends. Many nurses, of course, cannot get week-ends off, but if the demand were sufficient, mid-week Burnham trips would be perfectly feasible. With any luck, notices will appear in the East Wing, Nurses' Home, etc., for people to put their names on to let us know how many people would be interested in these schemes.

SAILING CLUB REGATTA, 1971

The Annual Sailing Club Regatta will be held on Thursday and Friday, 1st and 2nd July, at Burnham-on-Crouch. Everybody is welcome and sailing experience is not necessary.

The programme includes "wine, women and sailing", i.e.:—

1. Racing in Enterprises for the Ogilvie Cup.
2. Cruising in expensive keel-boats.
3. Banqueting at the Royal Corinthian Yacht Club (£1).
4. Dancing in the "submarine bar".
5. Palatial accommodation at the U.H. club-house.

Please sign lists, which will appear in East Wing, Nurses' Home, Physio School, and give £1 for the Regatta Dinner by Wednesday, 23rd June, to either Philippa Birch, Philip Meakins, Martin Bye or Graham Barker (c/o East Wing).

P. M. and G. B.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited for the post of **Lecturer** in the Department of Clinical Pharmacology, with duties to commence on 1st October, 1971. Initial salary, according to qualifications and experience, in the range £2,450—£3,926 per annum, plus superannuation. Forms of application may be obtained from the Dean, Guy's Hospital Medical School, London Bridge, S.E.1. and should be returned not later than **15th June, 1971.**

GUY'S HOSPITAL MEDICAL SCHOOL

Department of General Practice

LECTURER IN GENERAL PRACTICE

A community teaching unit for Guy's medical and dental students is being developed at Thamesmead (Greenwich/Bexley). The first permanent health centre will be opened towards the end of this year. Two members of the department are now engaged in developing the medical services as the population grows, and a third partner is now required. Applications are invited from doctors interested in a post that combines teaching and general practice. This partner will ultimately be expected to build up a list of 2,000-2,500 patients, but the first six months might be spent in a clinical or research department at Guy's and work begun during this period could be carried on while the list is building up. Remuneration would be derived from N.H.S. funds on the basis of the list size and from academic funds on a sessional basis. Full details and application form from The Dean, Guy's Hospital Medical School, London, S.E.1.

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited from registered dental practitioners for the appointment of **Lecturer** (full-time) in the Oral Surgery Department with duties commencing as soon as possible. Salary within the range of £2,450 to £3,926 with superannuation. Forms of application are obtainable from, and should be lodged with the Dean, Guy's Hospital Dental School, London, S.E.1, not later than Wednesday **23rd June, 1971.**

PERSONAL

FLAT TO LET in Blackheath. Doctor from Bart's going to Norwich for six months would like to let his smashing flat to three people who will look after it. Fully furnished, three large rooms, K. and B. and fabulous William Morris loo. Television, telephone, etc. etc., use of garden, nice neighbours. All for £16.50 per week, including rates but excluding gas, electricity and telephone. Anyone interested ring Dr. J. Mackinnon at Bart's, or his charming wife at 858-7814.

LADY with house in Orpington, wishes to share with another. Own sitting room and bedroom, share kitchen and bathroom. Reasonable terms. Box No. 3/6.

WOULD anyone at Guy's be prepared to assist in the translation of a scientific paper written in Hungarian? Please contact Dr. R. Grahame, extension 408.

ASSISTANT required with a view to partnership in well-established 3-man practice. 4 surgeries, laboratory etc. Modernised Georgian house in centre of Hampshire coast town. Full clinical freedom. Friendly atmosphere. Partners remuneration related to own gross takings. Box No. 1/6.

PART-TIME Dental Surgeon associate required for busy Caterham practice. Own laboratory, considerable amount of private work. Own nurse and complete clinical freedom. Blade implantology used. Excellent percentage offered Tel: Caterham 43999.

CHANGES OF ADDRESS

Mr. and Mrs. J. S. Batchelor, 37 Albemarle, Wimbledon Park Side, London, S.W.19. Tel: 01-789 7809.

Flt-Lt. C. A. Brooks, Dental Centre, R.A.F. Brampton, Nr. Huntingdon, Hunts.

Surg-Capt. (D) A. E. Cadman, R.N., Solent House, 2 Solent Way, Alverstoke, Gosport, PO12 2NS.

Dr. M. G. F. Crowe, "Ty Gwyn", 37 Ashfield Road, Leicester.

Dr. and Mrs. J. M. French, "Blue Rock", Trafrask West, Bantry, Co. Cork, Eire. Tel: Adrigole 17.

Dr. J. A. L. Leeming, 501 Lister Building, 195 Jeppe Street, Johannesburg, R.S.A.

Dr. Ashok Kumar, MacPherson P.O. 81, Singapore 13.

Dr. and Mrs. Sean O'Connell, "Winsford", 25 Heathside Road, Woking, Surrey. Tel: Woking 3589.

Dr. and Mrs. D. J. Openshaw, 13 Sunridge, Overndale Road, Downend, Bristol.

Dr. L. J. Turner, c/o Department of Surgery, University of Toronto, Toronto, Ont., Canada.

BIRTHS

BROOKS—On 12th October, 1970, to Colin and Heather in Singapore, a son Steven, a brother for Graham.

CARTER—On 20th May, 1971, to Denise (née Marsh) and Dr. Mark Carter, a son (David Antony). Present Address: Box 421, Glenboro, Manitoba, Canada.

PAUL—On 7th May, in Victoria Ward to Caroline and Robert (Bumble) Paul, a son, Dominic James, a brother for Anna and Clare.

WOOD—To Anne and John on 14th May, 1971, a little girl (Christine Anne) a sister for Paul.

DEATHS

REYNOLDS—On 23rd April, 1971, Clifford Alfred Reynolds, L.D.S., R.C.S., B.D.S., as the result of a car accident.

SMITH—In May, 1971, at Aberfeldy, Perthshire, Charles R. K. Smith, L.D.S., R.C.S.

GUY'S HOSPITAL GAZETTE

EDITORS N. D. S. BAX and A. M. TURNER
NEWS EDITORS R. M. DARLING and J. L. LEWIS
SPORTS CORRESPONDENT A. M. ROYSTON
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TEN PENCE VOLUME 85 NUMBER 2163

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

The Park is Exhausted

"The Park at the end of this Colonnade commemorates the ninety-four men and women of Guy's Hospital who gave their lives during the war of 1939–1945." And what use do we make of the memorial park described by the plaque in the Colonnade? Half of it is car park.

It would be difficult convincingly to argue that those ninety-four brave souls will be affected harmfully by cars choking up their memorial park. One of the things they died for was our freedom of choice. It is also less than certain that the park would afford any more architectural delight to idle connoisseurs if its details could be surveyed peacefully without the customary double line of cars on every available inch of road, and even sometimes on the pavement. Besides, that line so ably demonstrates the inverse laws both of attraction and light: the size and shine of the cars diminishes with distance along the road from Nuffield House, and has a certain charm of its own.

The buildings around the park have, of course, like those in most old hospitals, grown up at different times, leaving a façade of five large blocks of differing architectural styles with little oblong brick link pieces. With the exception of Nuffield, the buildings have only one unifying particular: they are all filthy on the outside. Hunt's House looks as if it has not been cleaned since it was completed approximately to the design of its architect Mr. Rohde Hawkins, in 1871.

No, neither a respect for the dead nor any aesthetic argument would convince that the park should not be used for cars. However, there is still the point that cars are noisy, smelly and dirty and improper intruders into a park where patients, nurses, staff and wicked students like to relax in the sun.

At the moment there is plenty of room behind New Guy's House for cars of staff and students on unused ground. When that closes there will be room elsewhere around the Tower Block. Let us recognise inside the hospital the rights of people on foot are prior to those of machines which offend all the senses and foul our buildings.

Diabetes Symposium

Of the 15 million diabetics in the world about 500,000 live in Great Britain. All these diabetics would die a slow, wasting death had not 50 years ago Banting and Best performed some experiments to show the efficacy of insulin, and MacLeod subsequently persuaded industry to mass produce it.

During the siege of Paris one hundred years ago, it had been noticed that starvation improved most diabetics. Diabetics were then starved—a most unsatisfactory state of affairs. Insulin has relieved all this.

An article in this issue by Mr. J. G. L. Jackson, the Secretary General of the British Diabetic Association, describes briefly the formation of this, the first patient-association. Although every medical student, doctor, nurse, dietician and so on knows the names Banting and Best, it is unlikely they will have heard of all the people Dr. J. Henderson mentions in his article. It seems likely that Banting and Best were the final, though at the time, somewhat haphazard final common pathway.

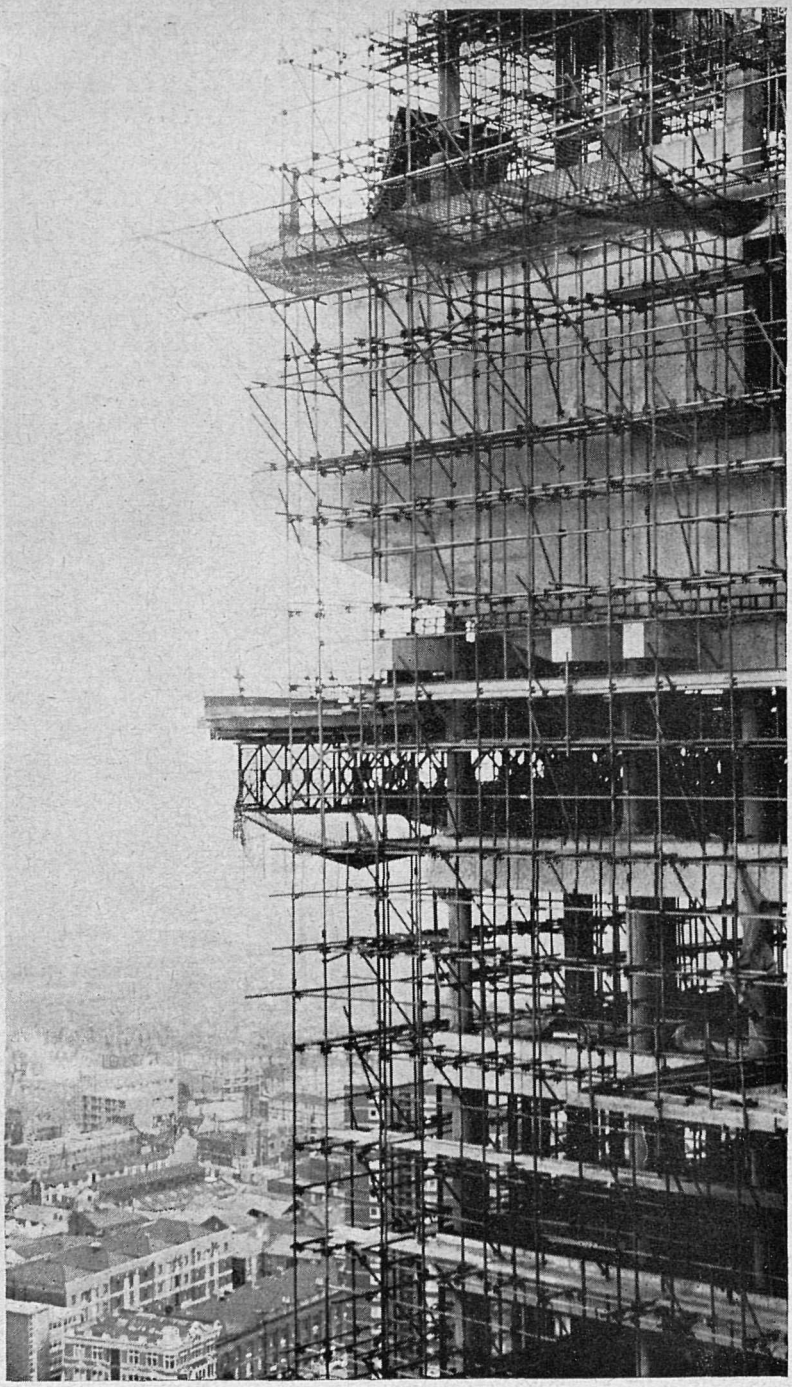
Dr. Asmal comments in his article on an aspect of research into diabetes that is presently occurring in the Department of Medicine at Guy's, work that is being supported by the British Diabetic Association, and in addition to Guy's, 20 other hospitals, medical schools and universities in the United Kingdom.

It has been estimated that insulin has played a direct part in prolonging and improving the quality of the lives of 25 million people since 1921. Even so, for every known diabetic there is probably a further unknown diabetic. Obviously, much has still to be done.

GUY'S DIARY

JUNE			
22	Tu	1.00	Clinical Lecture. Mr. BLACKBURN. "Goitre."
24	Th	1.00	Clinical Lecture. Dr. HARDWICK.
25	F	2.15	Combined Round. Dr. CLARK. "Hypoventilatory Dropsy (Cor Pulmonale)."
28	M	1.00	Clinical Lecture. Dr. WELLS. "Ichthyosis and Anhidrosis."
29	Tu	1.00	Clinical Lecture. Mr. BEARD. "Carcinoma of the Rectum."
JULY			
2	F	2.15	Combined Round. Dr. MACKENZIE and his Firm.

Prospect of the Thames from the Lecture Theatre at the top of the Tower.



Guy's new Lecture Theatre on a cantilever.

NEWS IN BRIEF

Congratulations

We would like to congratulate three Guy's graduates on atttaining the final F.R.C.S. at their first attempt : Chris Davies, Registrar in Genito-urinary surgery at Guy's; Bob Lane, Registrar at Pembury Hospital, Tunbridge Wells; and Neil Watson, Registrar in General and Genito-urinary surgery at Guy's.

In addition, the following were awarded honours in final M.B., B.S.: Angela Godsmark, John Camm, Mick Nielsen and Ray Wainwright. To these also we offer our congratulations.

Theatre Club Tickets

The next Theatre Club production is an evening of one-act plays including "The Zoo Story," by Edward Albee; "The Bald Prima Donna," by Eugene Ionesco; and "Two Gentlemen of Soho," by A. P. Herbert. It will run from 28th June to 2nd July, in the Physiology Theatre, at 7.30 p.m. Tickets are now available from Paul Marshall, *c/o East Wing, Guy's Hospital.*

New Postal Code

The Post Office has allocated the Hospital and Medical School a new postal code : SE1 9RT.

The Lamson Blues

The Lamson Tube system for transporting blood specimens etc. around the hospital has a popular reputation for unreliability. The feeling among medical students seems to be that if one has a blood specimen which one has obtained with considerable difficulty, it is wiser to transport it to its destination in one's own sweaty little hand than entrust it to the vagaries of the Lamson Tube. Only if the specimen is unimportant (should this ever be the case?) does one take the easy way. Some information on the system may be of interest.

When the carrier has been "posted" it proceeds to a sorting station, where the code which has been dialled on it is read by machine and it is thus directed to its destination. If there is any fault in the carrier, it is either directed to a reject station, or it jams the sorter, with a subsequent accumulation of carriers behind it. Such blockages occur about once a month, and may take two days to clear, using long rods rather as drains are cleared. 80 per cent of blockages are the result of faulty use of the system, carrier either being posted upside down (did you know there was a wrong way?) or posted with the lid not secured properly. Most of the remaining blockages are the result of people amusing themselves by pushing unsuitable articles, mainly bits of cloth and paper (request forms, urine bottles, and even a skirt have also been found in the tubes).

The tubes are tested every morning, and electrical and mechanical faults in the system are rare. One fault of the system is that its design allows the posting of a carrier upside-down—this will be rectified when the system is connected to that in the Tower. Carrier with lids which can be shut more effectively, and three rings to code for destinations in the Tower will also be introduced—6 prototypes are now in use, with the 3rd ring blocked off.

Sir Frederick Banting and Prof. Charles Best and Marjorie, who was the first dog to be pancreatectomised and kept alive with injections of insulin in 1921.

Photograph by kind permission of W.H.O./Best Institute and British Diabetic Association

1. Who Discovered Insulin?

J. R. Henderson

The great sagas of physiology do not begin "Once upon a time"; they begin with "Claude Bernard (eighteen hundred and something) showed that . . ." This particular saga begins with Claude Bernard in 1850 saying that it was technically impossible to remove the pancreas from an animal. For once the great man was wrong: the advent of anaesthesia and antisepsis subsequently made it practicable. But being a man of resource and sagacity, Bernard thought that the next best way of disposing of the pancreas was to inject a substance (he used denatured gelatine) into the main pancreatic duct, and this produced in his dogs a syndrome that would now be called steatorrhea. Bernard had no thoughts about an internal secretion of the pancreas, for endocrinology did not exist until after his death. So, unlike most of the people in this article, Bernard did not discover insulin—but his idea of disposing of the pancreas played a significant role in the ultimate discovery of the hormone.

Bernard's prediction about pancreatectomy was disproved in 1890 by Von Mering and Minkowski (as every text-book says). Exactly what made them test the urine of their ill dogs for reducing substances is not clear, but they did, and found the urine loaded with something that they assumed to be sugar. The flood gates, for want of a better expression, were open wide. The French histologist Laguesse remembered in 1891 an obscure M.D. thesis written thirty-two years before which had described some islands of cells scattered in the pancreas of the rabbit. Languesse, with remarkable charity, suggested that these cells should be called the Islets of Langerhans, and hazarded that they were producing something which normally prevented glucose from appearing in the urine. So it was Laguesse who first conceived the idea of insulin.

In the next twenty years the stage became filled with shadowy figures. The first of them was an extraordinary French physiologist called Eugene Gley. Everything was grist to Gley's mill; in 1891 he published twelve papers in the French Society of Biology on the thyroid, the adrenals, pancreas, central nervous system and heart. But what is relevant to us here is that he was very impressed with Laguesse's hypothesis, and made an aqueous extract of pancreas to give pancreatectomised dogs. The dogs, he noticed, had their glycosuria lessened, but became more ill than they were before. Wondering if this could be due to the enzymes in the exocrine pancreas, he tried Bernard's technique of injecting gelatine into the duct system, allowing the pancreas to degenerate, and then injecting an extract of this tissue into diabetic dogs. The dogs improved and their glycosuria lessened. This, as you will see, is almost precisely what Banting and Best did some twenty-five years later.

The only problem is how we should regard Gley, for it was at this point that he performed one of the more eccentric acts in the history of science. He wrote up his experiments, sealed them in a

packet, and in February, 1905, deposited them with the French Society of Biology, with instructions that the packet should only be opened at his request. We can only conjecture why a man should do such a thing; but Gley could have no clue as to the significance of his findings, and perhaps wasn't even quite sure that they were true. But since scientists published at that time a paper on a morning's work, or some odd thoughts they had on the weather, or life force, it would have only been a drop in the ocean if Gley had published his findings. He was clearly a good scientist, for in 1897 he was the first to show that removal of the parathyroids produced tetany, which he *did* publish. All this, it must be said, before the word hormone existed. As far as I can discern, Gley never returned to his pancreatic experiments of the 1890's, and when Banting and Best's discovery was announced in 1921, Gley (by now Professor of Physiology in Paris) instructed the Academy to open his packet. In it were the Canadians' experiments eerily done twenty-five years before. It must have been a very strange occasion. In all fairness, he gave no great detail of his work; in the manner of the time the article has few figures and no experimental protocols. But there is no doubt that the experiments would have produced the results that Gley presented. I am not trying to suggest that he should have been given a Nobel Prize, for it is a reasonable convention in science that priority of publication is all. Nor did the unfortunate Gley appreciate the significance of what he had done, for he was perhaps too far ahead of his time. He, I think, discovered insulin without knowing what it was.

The word "hormone" was coined by Starling in 1905 (the year of Gley's packet) and "insulin" by de Mayer in 1907. The trail became very warm. In 1908 Zülzer, in Germany, made aqueous pancreatic extracts, and after demonstrating their ability to lower the blood sugar of pancreatectomized dogs, tried it on human diabetics. Many of these showed striking clinical improvement, but the side-effects, which included pyrexia and hypoglycaemia, were as unpleasant as diabetes itself. By 1912 Zülzer claimed that he had overcome these side-effects, and he signed a contract with Hoechst Pharmaceuticals; they paid him 6,000 marks for the patent of insulin plus a percentage of the profits. But something went wrong—Zülzer got his money, but insulin never appeared on the market.

In 1912 E. L. Scott, in America, tried exocrine degeneration again. He tied off the duct, allowed the pancreas to degenerate and injected aqueous extracts of it into diabetic dogs. Once again there were pyrexial side-effects, due presumably to the protein in undegenerated pancreas, and Scott was fooled into wondering whether it was the pyrexia, and not the insulin, that produced the clinical improvement. He was also very unsatisfied with the crude methods of measuring blood sugar and devoted his time to that, without ever returning to the real problem.

The Rumanian Paulesco believed that the pyrexial side-effects seen by Zülzer's and Scott's extracts were due to bacterial contamination and not exocrine protein. He removed the pancreases from dogs

under aseptic conditions, ground up the tissue in ice-cold saline and injected the resulting extract intravenously. This technique produced a very severe fall in blood glucose in the experimental animal; in fact, Paulesco's first dogs given the extract died of hypoglycaemia. When given subcutaneously, the extract produced pain and tenderness. These results were presented to the Society of Biology in Paris in May, 1921, and sent as a full paper in June, 1921. The dates are important, because it was on 30th July, 1921, that Banting and Best gave their first pancreatic extract to a dog; they were as unaware of Paulesco's work as he was of theirs.

There was a good deal of excitement in Bucarest when Paulesco's discoveries became known. (He called his active extract "pancréatine"; whether this was out of perversity or ignorance of the name suggested by de Mayer in 1909 is not clear.) A committee was set up in Bucarest to discover the best way of purifying and making pancréatine on a scale suitable for the treatment of diabetics; but almost at once the news came from Canada that Banting and Best had made an extract, and that thousands of dollars were being poured into its development. Presumably with a few choice Rumanian expletives, the committee went home and never met again.

* * * * *

Frederick Banting set himself up in General Practice in London, Ontario, in July, 1920. The patients stayed away in droves, and like Conan Doyle in a similar situation, he wondered what he was really meant to do with his life. He went to work, part-time, at the Physiology Department in Ontario and spent a few months working on the cerebellum. On 30th October, 1920, he was preparing a class for the next day on the pancreas and discovered a recent paper on pancreatic stones. He wondered whether experimental blockage of the duct (i.e. tying it) would produce atrophy of the exocrine tissue and leave the islet tissue unharmed, enabling insulin to be extracted from the remnant. Banting at the time had no intimation of the utter unoriginality of this thought. He became obsessed with the idea of doing the experiment, and went to see J. J. R. McLeod, who was the foremost carbohydrate physiologist in Canada at the time.

McLeod was very crushing—he said that it had all been tried before (as we have seen), and by people with far more experience than Banting. But Banting was not put off; he appeared in McLeod's office the next day announcing that he had not put his case properly. All he wanted was space for two months, some dogs, and technical help. Perhaps to keep him quiet, McLeod acquiesced, and as McLeod was going on holiday, it was hardly any skin off his nose. Two students, E. C. Noble and C. H. Best, who had just finished their B.Sc. year, were organised to help, and as Noble was going on holiday, it was arranged that Best should help for the first month and Noble for the second. Noble, in fact, was ill when it came to his turn, so Best was there all the time. (There is an apocryphal story that they tossed up for the first go, but this is not true.) McLeod went off to Europe for the summer, and Banting and Best began, with little money and under awful conditions. At one stage they

had used up all the dogs, and Banting sold his Ford to get enough money to buy some more—he is said to have stopped strangers in the street and bought their dogs from them. Most of what they did was not new; they began by repeating orthodox duct-ligation experiments and made an extract which could keep a pancreatectomised dog alive. But the extract ran out, and they were forced to look elsewhere. Then Banting remembered an old observation of Laguesse that in foetal and neonatal animals the exocrine part of the pancreas was small compared with the islets, so hot-foot they went to the local slaughterhouse, and prepared an extract of neonatal calves' pancreases. It worked, and at last they had an insulin preparation which was available in reasonable quantities.

McLeod came back from his holiday in Europe to meet Banting and Best, who must have been cock-a-hoop. To McLeod's eternal credit, he realised the importance of their finding, and set aside some of his resources to improving the crude extract. A biochemist, J. B. Collip, was put on to the problem, and quickly showed that acid-alcohol extracts of whole adult pancreas were more effective than anything that had been tried before. It was almost ridiculously simple after the difficult duct-ligation experiments that Banting and Best had been wrestling with throughout the 1921 summer.

The award to McLeod and Banting of what must have been the fastest-ever Nobel Prize, occurred in 1923, and created something of a stir. Banting refused to allow McLeod's name to be first on the citation, so the order had to be reversed. Even then, it was difficult to see how a Nobel Prize could be given to a man who was on holiday at the time that the work was being done. Best was not even proposed (how could anyone give a Nobel prize to a medical student?), but Banting insisted on sharing his prize with Best, and McLeod, finding himself in a curious position, shared his half with Collip.

* * * * *

It is probably apparent by now that nobody actually discovered insulin. It existed first as an idea (Laguesse), then as a proven hypothesis (Gley, Zülzer, Allen, Paulesco), and finally as a practical way of alleviating diabetes (Banting). J. S. Mill said that a man with a conviction is worth twelve men with ideas; Banting, really, was the only man with a conviction, with passion, and all the others (except possibly Paulesco) were just ideas men. When the last insulin syringe has been thrown away, we may find that there were twelve ideas men, for in truth, almost anybody can have an idea. Ideas are the small change of science: it is conviction—zany, indestructible belief—that is the real pot of gold.

Some references :

GLEY, E. P. (1922) *C. R. de la Soc. biol.* **87**. (letter dated 20th February, 1905).

LAGUESSE, E. (1923) *Rev. Franc. d'endocrinologie* **1**, 281.

MURRAY, I. (1969) *Scottish Med. J.* **14**, 286.

PAULESCO, N. C. (1921) *Arch. Int. de Physiol.* **17**, 85.

SCOTT, E. L. (1912) *Am. J. Physiol.* **29**, 306.

STEVENSON, L. (1947) "Sir Frederick Banting". William Heinemann, London. 1st Edition.

2. Insulin Glucose Relationships in the Periphery

A. C. Asmal

On the 50th anniversary of the discovery of insulin, in paying tribute to the men who found it and revealed to the world its dramatic effect in lowering blood sugar, it would seem fitting to reappraise its actions on glucose metabolism.

Much is now known about its diverse physiological effects on various aspects of carbohydrate, lipid and protein metabolism. Many hypotheses have arisen to provide a unifying concept of its mode of action. The observation that glucose itself stimulates insulin secretion has strengthened the basis of the interrelationship between the two. That there is an association between insulin and glucose is clear. The impression that this is a simple one is false, as must have been evident to early clinicians noting the varied insulin requirements of their diabetic patients.

This review presents data derived from studies performed in the Department of Medicine, which may provide an estimate of the extent to which insulin regulates peripheral glucose metabolism. The studies are based on the forearm technique which permits an *in vivo* assessment of metabolic activity. Metabolic events have been investigated before and during the course of a glucose tolerance test, and are reported in terms of the peripheral uptake of insulin and glucose. The measurement of peripheral uptake rests on application of the Fick principle which relates uptake to arterio-venous differences and blood-flow.

Our data indicate that insulin has a significant action in promoting glucose uptake by the peripheral tissues, and reaffirm its established role in glucose metabolism. However, analysis of the relationship between insulin and glucose uptake to assess the degree of correlation, reveals no consistent pattern of correlation between the two. In other words, the passage of a specified amount of insulin from the circulation into the tissues is not accompanied by the simultaneous transfer of a predictable quantity of glucose. The implication is that the action of insulin cannot be the sole influence regulating the peripheral uptake of glucose. This lack of correlation between insulin and glucose uptake may be due to several factors, of which two—insulin sensitivity, and the lag between insulin and glucose uptake, will be discussed.

Fig. 1 displays a composite picture of glucose and insulin uptake in normal and obese subjects during the course of the glucose tolerance test. Apart from the fairly obvious disparity in the magnitude of the relative uptakes of glucose and insulin in the two groups, a striking feature is evident when the temporal relationships of glucose and insulin uptake are examined. It is clear that in both the normal and obese groups, the peak of insulin uptake precedes

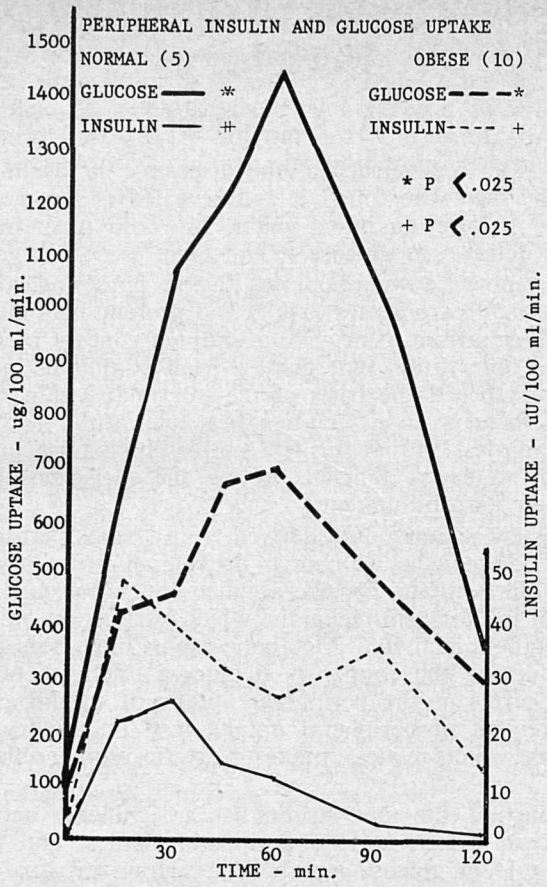


Figure 1

the one for glucose uptake. There appears to be an initial "build-up" of insulin before there is "activity". To allow for the time lag in assessing correlations, the glucose uptake was related to the insulin uptake of the preceding 15 minutes. Again no correlation could be found, thus leaving unexplained the apparently anomalous situation of "metabolically inactive" insulin.

In a previous study performed in collaboration with Dr. Rasio of Belgium, we demonstrated that a slow intra-arterial infusion of a physiological concentration of insulin for one hour was without concomitant effect on glucose uptake. Zierler also showed that the intra-arterial injection of small amounts of insulin did not increase glucose uptake, though significantly altering FFA metabolism. Meade and his associates produced elevations of the arterial insulin concentration within the physiological range by injections of pancreozymin,

and recorded that these changes did not induce falls in the arterial glucose levels. Such findings throw open the question of the nature of the relationship between insulin and glucose at the physiological level.

The possibility exists that the lack of correlation between insulin and glucose metabolism is a reflection of varying insulin sensitivity. If insulin sensitivity is defined as the ratio of glucose uptake to insulin uptake, we have also demonstrated in our present study, that this index varies not only from individual to individual, but also from time to time in the same individual, subject to the prevailing hormonal and substrate milieu. Within the physiological context the lack of a direct consistent relationship between insulin and glucose uptake reflects the varying insulin sensitivity and its dependence on the prevailing metabolic status. In the diabetic state the absence of a predictable association between insulin dosage and glucose response may in part represent an extension of this phenomenon of varying insulin sensitivity, exaggerated to some extent by the more severe disturbance in physiology from the excess elevation of FFA, triglycerides and ketones. The problem in diabetes is in any case complicated by other observed derangements such as abnormal capillary permeability, or presence of circulating insulin-binding antibodies.

Within the framework of our observations that there is no consistent correlation between insulin and glucose uptake, and with due regard to the absence of a constantly predictable effect of exogenously administered insulin on glucose metabolism, it is nonetheless possible to attempt a quantification of the insulin-glucose relationship. This we have done in molecular terms. We have estimated that in normal subjects, in the post-glucose state, the passage into the periphery of one molecule of insulin is accompanied by the transfer of more than 1,000,000 molecules of glucose. Depending on the existing metabolic situation, the range may vary from 1,000,000 molecules to 100,000,000 molecules of glucose/molecule of insulin. A change of this magnitude is difficult to visualise, but it is equivalent to the disposal of a 100 G load of glucose by less than two units of insulin. In obesity, a reduced amount of glucose is taken up per molecule of insulin (as is evident in Fig. 1). This is in accord with the well-recognised diminution of sensitivity to exogenous insulin in the obese state Further studies are in progress to delineate more clearly this association in diabetes. All observations to date, nonetheless, emphasise that as great as the influence of insulin on glucose metabolism is, it is not the sole factor regulating glucose uptake.

"Insulin is the hormone, par excellence, of anabolism". In pharmacological doses, its "physiological" importance in the life of the diabetic is unquestioned. The physiological significance of fluctuations of insulin at the cellular level, however, is in need of further elucidation.

Acknowledgement: These studies were performed under supervision of Professor W. J. H. Butterfield, and in collaboration with Drs. K. Karamanos, B. D. Cox, Miss M. J. Whichelow and Miss C. Snell, with the assistance of Staff-Nurse J. Cook.

3. The British Diabetic Association

J. G. L. Jackson

It all began through the impact of a dedicated Scot on an imaginative genius. In 1933, Dr. R. D. Lawrence, himself a diabetic, needed money for a diabetic clinic at King's College Hospital, London, and he persuaded H. G. Wells, one of his patients, to write to *The Times* about it. The response was so encouraging, and came from such a wide area, that both doctor and patient became convinced that among people afflicted with the same disorder, there was a strong fellow feeling which might be directed effectively into channels of mutual help. So Mr. Wells wrote again to *The Times* in 1934, suggesting the formation of an association of people interested in diabetes, either as patients, as doctors, or concerned in some way with diabetes.

The response was such that on 16th March, 1934, the first meeting of Foundation members was held in London. H. G. Wells was the natural choice for President, and Dr. Lawrence became Chairman of the Executive Council, consisting of both doctors and lay diabetics. Amongst the Vice-Presidents were the two Canadian doctors whose discovery of insulin therapy had made so revolutionary a contribution to the diabetic life, Frederick Banting and Charles H. Best.

Thus the first "patient" association was born; and through the intervening years the Association has pursued its initial aims to help the diabetic community to live full and useful lives and to sponsor research into the condition.

The advent of the National Health Service in 1948 increased rather than diminished the Association's activities, and these now cover a wide range of advisory services. Employment and insurance, car-driving and emigration, diet and cookery, holiday camps for diabetic children, special facilities, welfare services generally are some of the many aspects of living with diabetes on which the Association is able to give help and advice. In addition, educational activities for the benefit of those responsible for the care of the diabetic at home or in hospital are pursued, conferences organised in various parts of the country, and representation is made to Government and voluntary bodies in connection with the interests of diabetics.

Through the Medical and Scientific Section (composed of doctors and scientists interested in the field of diabetic care and research) and the Professional Services Section (comprising all those who are professionally responsible for some aspect of the diabetic life—dieticians, health visitors, district nurses, chiropodists and the like), the Association maintains close and valuable contact which is mutually advantageous.

Through literature, including a bi-monthly newspaper, *Balance*, and publications such as the *carbohydrate values of proprietary foods* and the *cookery book*, the Association provides an up-to-date service to its members and all those interested in the condition. Simi-

larly, through its 114 Branches throughout the United Kingdom, the Association is able to give help and assistance on a more local scale.

The support of research has always been uppermost in the aims of the Association, and we have established five Research Groups to whom support has been guaranteed for at least five years, in addition to short-term grants for specific projects. This support has been made possible only through the generosity of the diabetic community which has enabled us to distribute over £275,000 in support of research over the past fourteen years.

1971 marks the 50th anniversary of the discovery of insulin by Banting and Best in Toronto in 1921. To celebrate this occasion, the Association has launched an appeal for £500,000 for research and also to educate the public about diabetes. Professor Charles Best was invited over from Canada to join in the celebrations, including a National Thanksgiving Service at St. Paul's Cathedral. While he was in Britain, he gave several talks and lectures, including one at the Royal Society and another at the Association's Branches Conference.

The lead of the British Diabetic Association has been followed throughout the world, and there are now over 40 national Diabetic Associations who are members of the International Diabetes Federation. Close contact is maintained with them, as it is with any organisation which is able to help in our aim of ensuring that the diabetic in Great Britain is given every opportunity to play a full part in the life of the community.

Apology

In Mr. Rex Laurie's letter about the Wills Library in the last issue we spelt "Wills" incorrectly on five occasions. For this we apologise.

NOTICE

Charles Hastings Wine Club

Members of the B.M.S.A. are now entitled to apply for Associate Membership of the Charles Hastings Wine Club, ordinary membership of which is exclusive to members of the B.M.A. The Club was established in 1958 and its management is in the hands of a committee appointed by the B.M.A.

There is an entrance fee of 50p but no annual subscription. On joining the Club, Associate Members will receive the wine list which is issued periodically. An Associate Member automatically becomes an ordinary member of the Club without payment of any additional fee, provided that he becomes a member of the B.M.A. on qualification.

Further information and application forms are available from Dr. L. S. Potter, Hon. Secretary, Charles Hastings Wine Club, c/o B.M.A., Tavistock Square, London, WC1H 9JP.

NURSING SECTION

RACING TO THE COURSES

It seems that before any nurse nowadays can consider herself to have "arrived", she must have attended a course. The modern concept appears to be, that in order to make good managers out of everyone, that is the right and proper thing to do. It appears that there is a trio of first-line, mid-line and top-line management to be undertaken, and that these will last anything from one week to one month. Apparently, the comprehensive course lasting one year and thus ensuring an opportunity to assimilate some useful facts, is now as dead as the proverbial Dodo.

One sometimes wonders why all this is necessary, and what benefit, if any, will be derived. Particularly as the returning warriors appear no different or more efficient than before they went. However, if one has managed to avoid the net, and remain ignorant, it is possible, with the innocence of the uninitiated, to make a few observations, as one stands back and watches, while the crowds race by in the stampede to become "total nurses".

In the first instance, it appears one does not have the privilege of choosing which course to attend. One is told what is suitable. First-line management—for mere striplings—apparently can be taught in its entirety in the space of a week, and any old college will do for that.

When it comes, however, to the more serious business of middle- and top-line management there is, it appears, only one place upon which to concentrate. Mecca has nothing in comparison with its magnetism. The name, Liverpool! One is left to envisage Lime Street Station resounding to the quickening footsteps of students in their search for knowledge, their faces alert, and keen to catch every dropping pearl of wisdom.

The next question of the uneducated is naturally, what happens within the Sanctuary of Information situated as it is in a commanding position overlooking most of Liverpool's strip clubs?

Firstly, it appears each and every scholar has to introduce another one to the whole group. This has something to do with integration, one is told, but in fact, sorts out sheep from goats. All those who either trained or are working in a teaching hospital, are promptly ousted by the remainder. For there the time will be spent "proving their worth". Inverted snobbery, it appears, is still very prevalent.

Thenceforth and thereafter it seems one does not move unless motivated and with an objective! One does not talk, but has group discussions and feedback, and no one may work without a job description. Shall we, one muses, in a few years be querying our patients' motivation and objectives when they ask for a bedpan, or alternatively await the feedback from the question what would you like for dinner? This terminology is now flaunted nonchalantly by the educated, making lesser mortals feel totally inadequate.

In addition, it seems that the "play is the thing". Every situation must be acted out. Apparently the talents of Dame Edith Evans will be a basic requisite for nurses of the future. Perhaps they should attend RADA before commencing their training!

Also one must learn to talk for two minutes on such scintillating subjects as wallpaper. This attribute in addition to becoming an expert on statistics is apparently essential to the efficiency of British Hospitals. It also appears that students acquire a connoisseur's knowledge of curry, both the Indian and Pakistan varieties, during their excursions to the city.

Somewhere deep down in the mind of the observer something is stirring. A picture materialises, of girls in gymslips, talking to their fellow fourth-formers on such subjects as—wallpaper! The vision is faint as it all happened so long ago. Did one not, however, have to introduce one's peers, and learn to integrate? Is there not a feeling that somehow it has all been done before?

Maybe it is best left for each one to draw his own conclusions!

CORRESPONDENCE

Pathology

SIR,—I have read with interest your correspondent's letter (Mr. C. J. Bennet 21st May), and with sympathy the article by Professor Adams.

Having given "specials" in clinical pathology to quite a few of the "first passes" and coached many of the "failures" from Guy's over the past few years, may I as an outsider make a few comments:

I agree with Professor Adams that "nobody fails because he has not heard of von Willebrand's disease", but I have found that students coming here are grossly unfamiliar with the pathology of the material coming from St. Olave's wards e.g. malaria, worms, pernicious anaemia, unresolved lobar pneumonia etc., and here we teach on the current problems.

One must also support Professor Adams on the necessity of reading a sound textbook in pathology such as "Muir's Pathology". This in conjunction with organised lectures with clinical application is, in my opinion, essential. After all, a knowledge of the pathological processes is the root of the understanding of disease. I get the impression that pathology is considered a third-rate subject at Guy's, which has to be endured to qualify—where I came from pathology was given equal status with clinical subjects and was considered to be important to their understanding. Perhaps this is why we have a high percentage of pathologists amongst our graduates ?

It is, however, a tragedy that so many careers are halted by failure in these favourite subjects of mine which are so essential if a graduate is to understand the basic processes of disease. Until pathology is accepted and given a proper place in the curriculum without having to compete with venepunctures etc., and that it is shown that chasing the course of cross-infection or investigating a P.U.O. can be as exciting as saying "I've got an interesting case of . . ." (which the laboratory has probably diagnosed anyway), there will be no solution to the problem of examination results.

Yours etc.

JANE M. FULLERTON

St. Olave's Hospital,
S.E.16.

A plain man's guide on how to fail to teach pathology

SIR,—Once upon a time, O best beloved, there was a very wise physician. He had many patients passing under his care each year, and apart from his many other duties, he devoted a good deal of time to their treatment. But his patients were neither very happy, nor very healthy. "O Wise Physician!" they cried, pitiously, "Your treatment is no good—57 per cent of us died in the last plague!"

And he was very angry. Indeed, he waxed wroth (who did not appreciate it at all). "How dare the patients complain?" he stormed. "About 138 transfusions and 40 bottles of medicine are provided for each patient; as well as 70 tablets, some 20 pills and no less than 1,000 capsules! Yet it seems that only 25 per cent of the patients bother to attend my treatment sessions. Bottles of medicine are set out in the surgery every Wednesday afternoon, and hardly anyone comes to have any. No one takes a full or regular course of my lovely tablets. No wonder they die of the plague!"

But his patients were not always able to get to his treatment sessions, for they were at very awkward times, and their employers refused them time off work to attend. Many of them found the tablets had unpleasant side effects, the medicines were tasteless, and some of the capsules were hard to swallow.

But the physician was not moved, for he knew that death is *always* the patient's fault—they only die because they know it will annoy their physician. There was no need to make his drugs demonstrably effective or his potions palatable. This might, admittedly, result in most of his patients taking their medication regularly and eagerly; many of them would undoubtedly be in a better state of health. But as every physician worth his salt knew, that was no way to true health—softening of the options might set in (a dreadfully painful condition) and that was unthinkable.

Yours very sincerely,

MICHAEL A. SIMPSON.

Guy's Hospital,
London, S.E.1.

Not Cricket?

SIR,—Who are the "slightly selfish" people mentioned in the Preview of the Cricket Season, 1971 (22nd May, 1971), and why do they think it fit not to play for the Hospital? Perhaps one of them would be kind enough to enumerate his reasons for the benefit of readers of the *Gazette*.

From 1960-62, Guy's had one of the finest club sides in London. Players like Cook, Gibson and Bernard, who were county cricketers and University Blues, all gave the hospital their unstinted support on the cricket field. On one occasion in 1961, Guy's provided seven of the U.H. side.

It is most distressing to read of the present situation, and obviously individuals who divide their loyalties are not worthy of a Guy's training.

Yours, etc.,

N. J. KNOTT, B.D.S., L.D.S., R.C.S.(Eng.)

Flat No. 1,
Hawkeswell House,
Little Cheverell,
Nr. Devizes, Wilts.

Communication, the way to democracy

SIR,—The report in your last edition of the new medical firm at St. Olave's is the first official announcement of its existence that I have seen, other than the list of allocations to firms. There is something very wrong with staff-student communication when a matter of such obvious importance to the student body as a new firm is not even mentioned until over four weeks after its commencement. This is not an isolated incident, but an example of the gross failure of communication which bedevils the whole of Guy's. To allow hearsay to remain the largest and nearly sole source of information is to court trouble, as in this condition, sensational, inaccurate and malicious rumours gain amazing credibility.

Who can blame the student populace for apathy when they are kept so uninformed? Indeed, how can they be otherwise? Democracy cannot co-exist with ignorance, and one of the first objectives of any totalitarian regime is the monopoly and censureship of public information. Perhaps I am naive to believe that anyone wants a vaguely democratic system at Guy's.

Yours, etc.,

PAUL A. F. HEWISH.

East Wing,
Guy's Hospital.

Grants for Clinical Students

SIR,—Many of your readers must have been interested in a recent article on the activities of the National Union of Students. Too much is heard in the national Press of the destructive attitudes and obviously not enough of the constructive work which is going on unheralded in the background.

I noted with pleasure that a realistic view had been taken of the iniquitous Means Test system as applied to students' grants. Several years ago I wrote to the *Gazette* on this subject and also to Mr. Quintin Hogg, then M.P. for Marylebone. I pointed out that the difference between an allowance paid tax free and a similar sum of money found out of taxed income was unfairly large, and that even if a parent's income had to be considered, surely the allowance should in justice be paid and then subjected to income tax.

Neither this plea nor my surmise that this penalisation of the professional man was one of the reasons why children were not following in their father's footsteps brought a reply other than that he could not foresee either Party abolishing it.

I doubt if there is likely to have been much change of heart in the meantime. The suggestion, therefore, put forward by the N.U.S. that at least the clinical period should be exempted from the Means Test seems to me a realistic one under present circumstances. I hope they will continue to press for it. The abolition would be a real help and belated justice, particularly in families where more than one sibling wishes to enter the medical or dental profession.

Yours faithfully,

DAVID PLOWMAN.

7, Harcourt House,
19a, Cavendish Square,
London, W.1.

SPORT

H.O.P.

The time has come for the clubhouse down at H.O.P. to take on a new image. Sadly its present function is merely that of a changing room, the bar being used all too often for only the quick drink before departing.

A step in the right direction was seen with the arrival of a table-tennis table, however, whilst this is all for the good the transformation of the club house into a sports club for all Guy's people, has still a long way to go.

The introduction of a "football machine" similar to the one which is proving to be such a great success in the Guy's bar can only be an improvement. The placing of a "fruit machine" in the bar at H.O.P. is an idea which besides contributing to the entertainments at the club would have financial advantages too.

In comparison with Mary's clubhouse at Teddington, all the hospitals' sports clubs at Cobham, Bart's at Chislehurst, H.O.P. looks like the poor relation. Obviously complete redecoration and refurnishing is expensive, however, I think we must bare these in mind whilst making those changes we can afford now.

A. ROYSTON

SPORTS DAY

19th June, 1971, 3 p.m.

The Athletic Club, with the help of the ubiquitous "Angels" and many others, are holdng a new-style sports day this year.

With only a few true athletic events and many "social" events, there is something for everyone from consultants and their families to "Angels".

There will be consultants' events, children's events, a ward relay for the famous bed-pan trophy, and beer races. The highlights of the afternoon will be a contest of special events between the athletic club and the "Angels" with appropriate fluid prizes for all.

Teas will be served by gorgeous Guy's girls in the clubhouse.

B. JONES.

CRICKET REPORTS

MATCH v. DOVER

At Dover. 29th May. Lost

A selected team of Guy's and stray Dover players were put in to bat on a good Dover wicket. Langdon played a fine innings of 43 in 50 minutes, which, however, had its more boring moments such as four boundaries in the same over, all played with exactly the same shot off the back foot. The highlight of the Guy's innings was an excellent knock of 76 not out by Holland. This enabled Guy's to declare at 166 for six wickets after a late flourish of 20 not out by Davies.

Dover scored the runs with one over remaining, but only three wickets down. They were helped by some dropped catches and loose Guy's bowling.

MATCH v. KENT UNIVERSITY

At Canterbury. 31st May. Won

This was Guy's first fixture with the University of Kent. Owing to the delayed appearance of Davies, Rigg opened the bowling with Ramsay. Rigg did not live up to the early promise of having a straight six hit off his first ball. When Davies eventually made his appearance, his four for six helped to dismiss Kent for 94. Goodhart and Ramsay shared the other six wickets between them, each taking three for 25. This should have been an easy target even for a much weakened Guy's side. However, some poor batting and suspicious umpiring, meant that Guy's had lost eight wickets by the time they achieved their victory. Top scorer for Guy's was Goodhart with 31. Langdon contributed a useful 23, and Young was the only other player to reach double figures with 12 not out.

GUY'S v. REIGATE PILGRIMS

Sunday, 16th May

This performance was probably one of the worst in the whole history of the Guy's Cricket Club.

Reigate Pilgrims were dismissed fairly cheaply for 118, although one felt that had the Guy's bowling been more accurate on this helpful bowling wicket, the score would have been somewhat less.

The Guy's innings lasted approximately one hour, in which time the vast total of 27 runs was acquired—no further comment is required.

For obvious reasons, I have not listed the names of the team.

MATCH v. DRAGONFLIES

Saturday, 22nd May. Won.

This was a very good win on a very dull day. Guy's batted first. The openers were out quickly (Langdon to a very dubious lbw decision, and Gillham flashing), but Evans riding his luck well (he was dropped three times before he had scored 10!), began to bat fluently, and in particular produced some very excellent off-drives. Rees, at last, began to put bat to ball and scored a good 29, whilst Evans went on to make a very good 81. With Fitton and Burns providing the middle order "wag" (we had no tail because, as usual, we had a team of 10 men—Croft was suffering from a hang-over and couldn't get up), we ended up with 180.

We thought that the Dragonflies could walk away with the match, as the openers scored fluently, but after a stiff "pep talk" from the other members of the team, Davies began to bowl with some fire after tea and wickets started to fall. Some good catching and fielding kept the runs down and we eventually won with four overs to go. Davies bowled the best he has done so far, and took seven wickets for 41 and was ably supported by O'Keefe (these two opened the bowling and bowled 21 overs apiece unchanged), who took three for 69.

1st ROUND CUP MATCH v. KING'S

Monday, 24th May. Won

King's were put in after Guy's won the toss. I have never seen two such bad batsmen score so many runs as the openers. They flashed, played and missed, hit the ball in the air, and were given not out, but we could not get them out. Apart from that, at least four catches were dropped. The opening stand was 46, but when three wickets fell with the score at 56, the position looked healthier. At last the catches were held, and Evans was in good stumping form. The fifth wicket stand was 50, but we got the last four wickets for four runs, and King's were all out for 137. O'Keefe bowled very well to take four wickets for 11, and Ramsay (three wickets in 21 overs) and Danford (two wickets) also bowled sensibly.

In the fifty minutes before tea, Langdon and Fitton scored 75 runs, and it looked as if we might win by 10 wickets. Langdon was at last attacking the bowling and hitting the ball hard. Fitton started slowly, but soon caught up, and with both batsmen on 46, it was a toss-up as to who would reach 50 first. Fitton missed his chance, and Langdon got his, at the same time as the 100 partnership came up, but was unfortunately run out soon after for 52.

This was the first opening partnership of any size this season, and it certainly gets the innings off to a good start. Fitton got his fifty, but due to the pint the two openers had on the highest score, began to stagnate and was eventually out for 50 and lost the bet. He had made 50 off 68 balls, and Langdon 52 in 58 balls—a very reasonable rate of scoring.

Goodhart tried his best to get out, but did not succeed, and Evans hit a couple of good shots to ensure that we won the match comfortably by eight wickets.

This was a very good win, mainly due to the fact that we had a good team out for a change. Let us hope we can beat Mary's as easily in the second round.

CHRIS. LANGDON

GUY'S v. H.A.C.

Saturday, 15th May

Guy's won the toss on a gloomy day and asked H.A.C. to bat, mainly because, at 2.15 p.m., only four opponents had arrived for a two o'clock start.

Guy's bowled and fielded well to restrict H.A.C. to 100 for 8, but then relaxed somewhat, and the H.A.C. declared at 164 for 9. Henriques bowled throughout, taking 5 for 75, and Danford supported well with 4 for 48.

Guy's made a promising start through Langdon (21) and Gillham (19 n.o.), but unfortunately when the score reached 50 for 1, the heavens opened and the match had to be abandoned.

Team: Goodhart, Langdon, Powell-Jackson, Gillham, Davies, Barford, Evans, Holland, Hogan, Henriques, Croft.

GOLF

GUY'S v. PRESIDENT'S TEAM

Tambridge G.C. Sunday, 25th May. Drawn $4\frac{1}{2}$—$4\frac{1}{2}$.

The annual battle with the President's team of experts was held at Tambridge G.C. on Sunday, 25th May.

Once again, the students were attempting to dislodge Dr. Maclean from the office of President, and once again they were thwarted.

Dr. Maclean fielded his usual team of experts, but this year were further strengthened by Dr. Brian Morris playing off three.

The clouds began to gather as we approached Tambridge, and by the time play was due to start, the weather had become decidedly damp.

After the foursomes in the morning, the teams were dead level, and the pressure was on the President's team, and this was reflected by the odds offered in Dr. Maclean's book at lunchtime.

The singles were played under much brighter conditions, and Michael Breen led off for Guy's against Martin Christmas an ex-Walker Cup golfer. Mike Breen in his own words once again became a "Christmas present" but not without a great fight after being four down with four to play he lost by two and one.

Dai Rowley-Jones was matched against Dr. Richard Cockerill, the local expert. Dai struggled hard, but could make no impression and lost two and one.

One of the more exciting matches involved Neil Davies playing against Dr. Maclean's new star. Dr. Brian Morris. The golf was to an extremely high quality with Neil Davies finishing with four threes to win on the last green, and in the process, shooting a highly impressive 72.

Richard Ibbetson and Ted Bray had satisfactory wins against their opponents, Mr. Brain and Professor Cohen respectively by margins of three and two and four and three.

Thus the whole match and Dr. Maclean's continuance as President, depended on the result of Dr. Maclean's match against Paul Powell-Jackson. They stood all square on the 17th tee, and the pressure was clearly seen in both players. However, Dr. Maclean proved himself the master of the situation by actually settling the match at the 17th with a very fine par four, and then proceeded to secure the match by an equally fine par four at the 18th.

The whole match thus ended in a draw, and Dr. Maclean continues in office as President. This is only the second time the match has ended in a tie, and Dr. Maclean is still undefeated.

After the match we repaired to Dr. Maclean's house and enjoyed a superb buffet dinner prepared by Mrs. Maclean, to whom we extend our warmest thanks. We should like to thank Dr. and Mrs. Maclean for all the extremely hard work that is done to make this day the highlight of the Guy's golfing year, and we look forward to the match next year when hope to maintain the pressure on Dr. Maclean's team.

RICHARD IBBETSON.

HOSPITAL INFORMATION

GUY'S HOSPITAL

Applications are invited for the appointment of **Senior House Officer/Registrar** in Clinical Pathology with duties to commence as soon as possible. This post provides a three-year training programme covering microbiology, clinical chemistry, haematology and morbid anatomy and is recognised for training for the M.R.C (Path). Appointment will be at S.H.O. level in the first place with promotion to Registrar after one year. Forms of application are obtainable from and should be returned to the Superintendent, Guy's Hospital, London S.E.1, not later than **3rd July, 1971.** Candidates are invited to visit the various departments.

GUY'S HOSPITAL

Applications are invited for the appointment of a **Senior Registrar** in Clinical Chemistry with duties to commence on 1st August, 1971 until 30th September, 1972 in the first instance. Forms of Application are obtainable from and should be returned to the Superintendent, Guy's Hospital, London S.E.1, not later than **3rd July, 1971.**

PASS LIST

UNIVERSITY OF LONDON

Second Examination for Medical Degrees

R. S. Armstrong
I. Bandak
D. J. Bickle
D. P. Brodie
C. R. Cairns
S. C. Callender
Sarah M. Cardew
Dianne P. Carter
C. G. Chinery
A. C. Chu
J. E. Clarke
Susan E. Comrie
M. K. Darcy
P. G. Davies
K. D. Dawkins
M. A. Durkin
Fong Keng-lao
I. C. Forgacs
J. R. Fraser
P. K. Gillman
Jennifer A. Goodwin
J. E. Gornacz
S. A. Green
I. E. Hanner
J. R. Hanson
Anne P. Hemingway
P. D. Houghton
C. B. Howard
P. A. N. Hutton
W. Jago
H. W. Jones
M. P. B. Jones
G. A. Kenning
M. T. Knox
Jill M. Krafft
C. G. Langdon
M. I. Levene
P. E. Lewis
I. F. Mackenzie
B. K. McLeod
R. F. Massey
P. G. W. Meakins
S. D. Milnes
Mok Hing Hung
Victoria R.-J. Muir
J. L. Ogle
S. A. Olczak
J. J. Oram
Julia J. Paskell
J. G. H. Pearson
D. M. Preston
C. J. Pugh
J. M. Ramsay
M. F. Randera
J. Richardson
B. D. Rix
Frances M. M. Rochford
Anna Z. S. Rohatiner
L. D. Ross
R. M. Rowland
P. H. Rowlandson
R. C. Saumarez
M. F. Scott
P. S. Sebel
Melanie G. Sharman
N. J. Stalley
J. E. T. Stokes
D. M. Thomas
T. J. Thornton
J. S. Tilley
P. T. Townsend
Angela E. Warren
P. J. Wheeler
B. G. Whiteside
M. J. Wink
A. P. Wozniak
C. M. V. Wright
J. Wynn-Jones

Third M.B., B.S.

Honours

A. J. Camm
Angela W. Godsmark
M. S. Nielsen
R. J. Wainwright

Pass

C. C. Baker
J. L. Bates
R. G. A. Behrman
D. Bellamy
R. Manna
M. A. Mansell
M. R. Masser
G. C. K. Nkwazi
S. R. D. Coles
Irene D. Cormac
Rosalind C. S. Dow
T. Dutta
H. K. C. Fan-lun
R. A Gude
S. R. Hammond
J. G. G. Hanley
P. R. Harrison
T. W. Higenbottam
Alison P. Hill
S. D. Horsley
Frances E. Jones
N. A. G. Jones
B. R. Kenning
Jean M. Knox
A. Lalani
C. J. L. Logan
J. K. Mackenzie
N. R. T. Pashley
G. Peters
J. A. G. Punt
J A. Quant
J. Rawlinson
P. W. L. Ribet
D. F. A. Rehards
Linda J. Rockall
C. G. Rowland
R. H. Savage
M. Schroder
J O. Soul
R. S. Stanley
Rosalind J. Thorburn
A. R. Valentine
R. D. Ward
J. A. H. Wass
Deirdre C. T. Watson

Part I

A. J. L. Brain
Margaret L. Cann
N. P. D. Downing
W. Edmonds
L. P. Harrison
G. M. A. Heaton
D. M. Hunt
Sarah A. Lange
E. G. Latimer-Sayer
B. V. Martindale
A. M. Ross
Loretta Salter
Morna J. Van Essen

Part II

N. P. D. Downing
Gillian L. Hoare
Vivien A. Leask
D. V. P. Thomas
R. G. Thompson
Morna J Van Essen
D. E. Ward

Part III

S. E. T. Bowden
B. Dick
Gillian L. Hoare
Vivien A. Leask
D. Macdiarmid
R. H. Mackay
J. H. S. Sargent
D. E. Ward

Part IV

A. I. Attwood
S. E. T. Bowden
B. Dick
N. P. D. Downing
Gillian L. Hoare
Alison Ironside
D. Macdiarmid
R. H. Mackay
S. J. D. O'Keefe
J. H. Reynolds
Anne R. Soul
G. C. Taylor
Morna J. Van Essen
C. B. Vulliamy

UNIVERSITY OF OXFORD

2nd B.M.

Pharmacology and Principles of Therapeutics

S. J. Farrow
Jennifer M. Kirkwood
Barbara M. Orr

General Pathology and Bacteriology

R. C. B. Odgers
Barbara M. Orr

Special and Clinical Pathology

D. A. G. Cook
M. H. Davies
M. A. Lavelle
D. A. Roper

ROYAL COLLEGE OF PHYSICIANS OF LONDON

M.R.C.P.

Gillian W. M. Baird
D. L. Beales
C. D. Erant
M. G. Falcon
C. E. L. Freer
R. M. Ibbotson
I. M. Jessiman
J. G. L. Morris
M A. Preece
J. C. Robertson
G. D. Schott
P. Sheridan
J. D. Spencer
P. G. F. Swift
P. L. D. Walde

PAPERS BY GUY'S MEN

Anderson, J. A. D. Rheumatism in industry: a review. *British Journal of Industrial Medicine*, 1971, **28**, 103.

Appleyard, W. J. Keeping on the "Medical Register". *British Medical Journal*, 1971, **2**, 172.

Calne, D. B. and others. Action of thymoxamine on mydriasis induced by Levodopa and Dopamine. *British Medical Journal*, 1971, **2**, 438.

Cockayne, E. The wrong end of the stethoscope. *World Medicine*, 1971, **6** (May 9th), 45.

Davies, H. and Dow, J. Differential pulmonary vascularity and the orientation of the right ventricular outflow tract with special reference to corrected transposition. *British Journal of Radiology*, 1971, **44**, 258.

Emslie, R. D. Clinical trials of treatment for acute periodontal diseases. *International Dental Journal*, 1971, **21**, 33.

Fox, C. A. and Fox, Beatrice. A comparative study of coital physiology, with special reference to the sexual cimax. *Journal of Reproduction and Fetility*, 1971, **24**, 319.

Herbert, W. E. National University of Iran School of Dentistry. *British Dental Journal*, 1971, **130**, 299.

Joseph, J. and Dyson, Mary. The effect of mechanical obstruction on tissue regeneration in the rabbit's ear. *British Journal of Surgery*, 1971, **58**, 277.

Macdonald, I. and another. Variations in the levels of cholesterol and triglyceride in the skin surface fat during the menstrual cycle. *British Journal of Dermatology*, 1970, **83**, 473.

O'Doherty, N. J. Neurological foundations of motor behaviour in infancy. *Physiotherapy*, 1971, **57**, 144.

Redpath, T. H. Orofacial symptoms in psychiatric disease. *Dental Practioner*, 1971, **21**, 301.

Rees, R. J. W. and others. The minimal inhibitory concentrations of sulphadimethoxine and sulphadoxine against *Mycobacterium leprae*. *Leprosy Review*, 1970, **41**, 223.

Walde, D. and others. Hyperosmolar nonketotic diabetic coma: with particular reference to vascular complications. *British Medical Journal*, 1971, **1**, 85.

Wright, D. J. M. and another. The significance of cardiolipin immunofluorescence (CLF). *Proceedings of the Royal Society of Medicine*, 1971, **64**, 419.

Wright, D. J. M., Turk, J. L. and another. Cell-mediated immunity and lymphocyte transformation in syphilis. *Proceedings of the Royal Society of Medicine*, 1971, **64**, 426.

PERSONAL

LADY with house in Orpington, wishes to share with another. Own sitting room and bedroom, share kitchen and bathroom. Reasonable terms. Box No. 3/6.

PART-TIME Dental Surgeon associate required for busy Caterham practice. Own laboratory, considerable amount of private work. Own nurse and complete clinical freedom. Blade implantology used. Excellent percentage offered. Tel: Caterham 43999.

ASSISTANT required with a view to partnership in well-established three-man practice. Four surgeries, laboratory etc. Modernised Georgian house in centre of Hampshire coast town. Full clinical freedom. Friendly atmosphere. Partners remuneration related to own gross takings. Box No. 1/6.

SELF-CONTAINED APARTMENT, Bermondsey Street, S.E.1. Completely modernised and refurnished. One double, two single bedrooms, lounge, modern kitchen, Luxury bathroom. C.H., H. and C., telephone. To let for a period of approximately one year. £20 per week. Tel: 722 1476.

BIRTHS

BUSH—To Ann (née Paskins) and Dr. Peter Bush, a son, Edward Kennedy Duyland, on 6th April, 1971 at Zachary Merton Maternity Hospital, Rustington, Sussex.

COCKERILL—On 14th May, to Doreen (née Howell) and Dr. Richard Cockerill, of Oxted, Surrey, a welcome fourth daughter (Kate Louise).

CHANGE OF ADDRESS

Dr. I. A. Baker, 2 The Hermitage, Eliot Hill, London, SE13 7EH. Tel: 852 9815.

ENGAGEMENT

JONES—CHESTERFIELD—The engagement is announced between Dr. Ian V. Jones of Flat 4, 9 Pond Road, Blackheath, S.E.3, and Miss Jane Chesterfield, Woodlans Court, Withdean Road, Brighton 5, Sussex.

We would like to remind our readers that all copy for inclusion in the "Gazette" must be received eight days before publication date.

Copy may be sent to us c/o The Front Lodge, Guy's Hospital.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, please indicate whether or not this should be published.

Personal notices 5p per word (pre-paid) (minimum £1.05).
Non-subscribers will pay £1.05 (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

EDITORS N. D. S. BAX and A. M. TURNER
NEWS EDITORS R. M. DARLING and J. L. LEWIS
SPORTS CORRESPONDENT A. M. ROYSTON
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TEN PENCE VOLUME 85 NUMBER 2164

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

The most recent Abortion Act has been exposed to an almost overwhelming attack from two opposing sides. Those who favour abortion think the act is unfair for two reasons; firstly, abortions are being denied to pregnant women who live in areas where the gynaecologists are loth to perform the operations in circumstances that other doctors would accept as reasonable grounds for an abortion. Secondly, many people think that when a woman has decided she does not want a conceived child, that would be a justifiable grounds for an abortion, for such a woman would be a bad mother. The Act should be made more explicit, according to these people, so that they are entitled to give an abortion in such a case.

Those who disagree with abortion also oppose the Act because they think it leaves far too much open to personal choice on the part of the doctor and gynaecologist. It allows an individual interpretation of the severity of social or psychological indications required to justify an abortion. Many, for religious or other reasons, believe it is wrong to destroy a foetus. For them, our country's laws should follow generally agreed, straightforward, moral laws. They submit that the people's morality follows closely the legally respectable tradition of the country, so making abortions available on any but the most restricted grounds encourages irresponsible promiscuity because the consequences of such behaviour will no longer be a possible life of misery for both mother and child.

We have on one side a group proclaiming women should not be expected to provide for a foetus merely because she has conceived him or her. An expectation of such a provision would be unfair both on child and mother. Similarly if a child is likely to be handicapped, that group would claim that we do not provide properly for such children, so it is not fair to nourish them at all, and also, a more extreme argument, that there are enough children in the world without actively encouraging the birth of the structurally handicapped.

There seems to be no easy side for Truth to jump to. Many claim that the belief that the life of a foetus should be given priority over the possible stability of the mother and other children is unrationalised and emotional, and that we should put the conventional stability of the mother before the life of a child is rationalised logic. They are, of course, aided by reports of one man who refuses to perform "social" abortions, a professor of gynaecology, who last week was reported to have said "We despise the doctors who do abortion on demand". Such argument cannot bring his antagonists to treat him with anything but contempt.

So we have a demand from both sides for a change in the law. But what could we hope to achieve? There remain many who, with clearly thought reason, consider that the destruction of the life of a foetus is the last very bad step out of a miserable situation : that the laws should be changed to provide more free contraception and advice for it, more help for unmarried mothers, more help for illegitimate and orphaned children, and more help for the handicapped. Only then could we hope that the stigmata arising from all those handicaps should disappear. They believe that the only justification for an abortion is when it appears that either the mother or the child will probably die, and possibly both will, if the pregnancy is allowed to continue. Then they have to make a decision for one or the other, and it is reasonable to bring social factors into account. There also remain those who have the intuition that an unborn child has few rights which preclude the contrary desires of a mother. We have no way of reconciling the two sides to their own satisfaction. Moral problems such as those have no clear definite answer which all will accept. The law must remain vague to allow both sides to live tolerably until we can provide a life that very few can deny is worth the living for people at present considered handicapped, whether physically or socially.

GUY'S DIARY

JULY

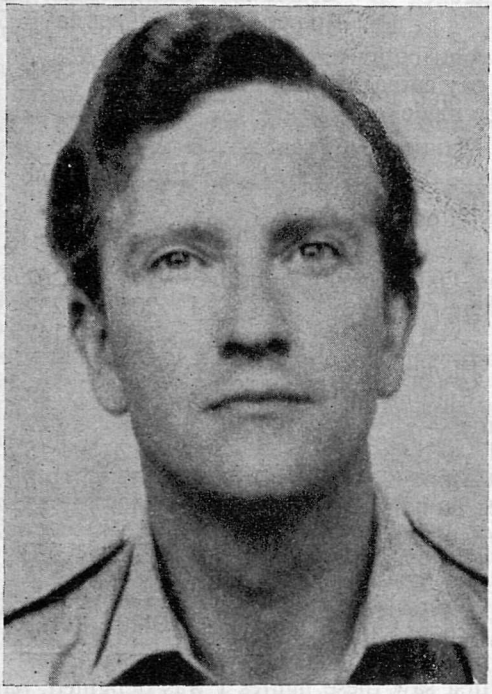
5 M 1.00 Clinical Lecture. Professor BURROWS, Chief of Professional Education, Mendocina State Hospital, U.S.A.
"The Battle of the Sexes."

13 Tu 1.00 Clinical Lecture. Professor LESSOF.
"Allergic Reactions in the Body."

NEWS IN BRIEF

Ian Howat Memorial Prize

The Medical School has recently received the very generous gift of £2,000 from Mrs. W. E. Howat to endow a new prize to be named the "Ian Howat Memorial Prize", in memory of her late son, Dr. Ian Howat, who was killed in an air accident while working in Lesotho. The prize, to the value of approximately £170, will be awarded annually by the School Council to a medical student who wishes to spend his elective period in a tropical country.



The late Dr. Ian Howat.

Tewfik Prize for Surgery

The School has gratefully received a bequest of £1,000 under the will of the late Dr. I. Tewfik, a Guy's man, who died in 1968. The bequest is to endow an annual prize of approximately £85, to be known as the "Tewfik Prize for Surgery", which will be awarded annually to the student who, in the opinion of the Council of Governors, is the best candidate in surgery in the last year of his training to qualify as a medical practitioner. In 1963, Dr. Tewfik endowed the Tewfik Prize for Anatomy and Physiology.

Grants—the last word ?

My previous article gave a brief outline of the grant increase, but here in more detail is how it will affect us:—

		Present.	1st Sept., 1971
1.	Clinical grants :		
	(a) Medical grants	£15	£20
	(b) Dental grants	£45	£60
2.	Mature Students' grants	£24—£120 p.a.	£29—£145 p.a.
3.	Extra attendance (i.e. 18 weeks):		
	London £1 per day	£1.40 per day=£9.80 per week.	
	Elsewhere £1 per day	£1.20 per day=£8.40 per week.	
	Home 57½p per day	70p per day=£4.90 per week.	
4.	Parental contributions :		
	Residual pay earnable before contributions must be made	£900	£1,100

5. Ordinary Maintenance grant :

	Present	1971	1972	1973
Board and Lodging :	£	£	£	£
London, Oxford and Cambridge	245	267	275	285
Elsewhere	205	232	240	250
Home	130	147	150	155
Common Elements :				
Books, Equipment and Materials	40	48	51	54
Vacation	38	42	43	46
Travel	12	15	15	15
Pocket Money	43	48	50	52
Clothes, laundry and dry cleaning	42	45	46	48
Total	£175	£198	£205	£215
Grand Total p.a.	£420	£465	£480	£500

When I first saw these figures I was delighted, particularly with the extra weeks study grant of £9.80 per week. However, on closer examination and calculations, I realised that we were *still* being lumped together with non-clinical students—the grant for "common elements" is the same for *everyone.*

Excluding vacation and travel grants, in 1971-72 everyone will receive £141 "common elements" grant, this gives :

Non Clinicals	£4.70 per week for 30 weeks.
Clinicals	£2.93 per week for 48 weeks.

Do our extra 18 weeks study, which includes new subjects, mean that we spend less money on books, clothing, and wash less frequently than other students—or do we live reasonably for 30 weeks and then not bother at all for the other 18?

The Board and lodging grant gives us £8.90 per week in 1971-72, as against £8.16 at present, for a 30-week term. We will, in future, receive £9.80 per week for the extra 18 weeks, deducting the board and lodging figure, this leaves us with 90p to live on—depending on how one interprets the "common elements. To be fair, this does not include fares (anything in excess of £15 will theoretically be refunded).

I am sure the D.E.S. would say that our grant is to cover a whole 12 months, not just 30 or 48 weeks, in which case we are getting an extra 90p per week for 18 weeks, plus a £20 or £60 clinical grant for the whole of our clinical training. How many non-clinical students budget for the whole year on their grant? They would not dream of it. How many work during the vacation to pay off the overdraft which they incurred during the term?

I am not ungrateful for the pay rise, particularly in the present economic situation, but I feel that it is about time the Government recognised the fact that we are in a different situation from non-clinical students.

Lynne Hampson,
Student President.

St. Christopher's Palace

This beautiful edifice of late Victorian architecture which adorns Long Lane is not the nurses' home (as a number of local residents think) but Guy's proud, and only present, residential quarters for clinical students.

It has matured over the years from a primaeval leather warehouse; spending its mediaeval period as asbestos warehouse and emerging from the Renaissance as part of the St. Christopher's Fellowship. Its purpose then was the resettlement of working men—good training, perhaps, for its present use. During the war it was bombed remarkably unsuccessfully and in 1947 was purchased by Guy's as a home for its 30 students, the nine fire escapes and a Warden.

Our palace cannot lay claim to such luxurious accommodation as the new mammoth hostel will, but an interest in Victorian furniture and a delight in comfortable and varied rooms satisfies most of its residents. Contrary to popular rumour, there is an unending supply of hot water and electricity and the rent of £3 is remarkable in its modesty, for it includes all our facilities, e.g., car park, TV, piano, showers, cooking facilities, etc.—not to mention the three lovely handmaidens who maintain a state of cleanly organisation from prospective chaos.

With the advent of our new warden came a much-needed loss of the archaic rules, and Guy's hostel now enjoys the liberality of the '70s, in fact, the near future promises a face-lift, and despite a tradition of Guy's blue, the front door is to be an iridescent red.

Being but five minutes' walk from the hospital ($1\frac{1}{2}$ mins. flat out if you are about to miss another 9 a.m. lecture), its situation does have many advantages. Not only is it detached from two adjacent green open spaces (officially described as bomb sites) but it is a mere 30 seconds away from a great variety of hostelries which cater for all interests from a look at London's gay people to the regular Sunday morning striptease.

Despite all these advantages, it appears that nobody has their name on the entry list and there are some places becoming vacant in July.

Can it be that all the students are so affluent as to afford their own penthouse suites, or is it that they feel their freedom would be too restricted? This, I assure you, would not be so. Most likely they have never heard of the place—if so, the matter is amended.

A.R.

NOTICE

MEDICAL ASSOCIATION FOR PREVENTION OF WAR

Meeting on

PROBLEMS IN COMMUNICATION

Newnham College, Cambridge,

Friday 9th July to Sunday, 11th July, 1971.

There are usually two or three bursaries available to pay for students going there and anyone who is interested should contact Dr. Ronald Mackeith.

"Where our Caravan has Rested"

or

Dental Care of the Handicapped Child in the Community

J. Nagel, P. Pearson, D. Pool, W. J. Tulley.

Over the past ten years the Dental Department for Children has been undertaking the treatment of children with a wide range of handicapping conditions. Dr. Mary Sheridan (1966) defined a handicapped child as one who is "suffering from any continuous disability of mind, body or intellect or personality likely to interfere with normal growth, development and capacity for learning".

It might seem that dental problems are of little significance to the well-being of the child who has multiple severe handicaps and that there are many other aspects of their care which demand prior treatment. However, anything that can be done to improve the social acceptability of these children is very important, particularly to their parents, and an unsightly and ill-cared for mouth can be avoided.

Swallow (1965) showed that handicapped children are no more susceptible to dental disease than normal children, although they may suffer more from inflamed gums. However, their mouths are often neglected because of their inability to clean their teeth either naturally or artificially. They often have a soft diet which is detrimental and regular dental treatment may be difficult to obtain.

To illustrate one of the many special problems, it is worth describing the example of a child with a tumour of the brain stem who has complete paralysis of the facial and lingual musculature. Her mother was recommended by a school teacher to rub the child's gums with honey to cure dental pain—this sweet sticky substance exacerbated the dental caries and all the teeth became involved with exposure of the "nerves". This child must have suffered intense pain without being able to communicate at all. Her teeth had to be extracted to bring relief despite her critical condition and very poor prognosis. Four years later the child is still alive and happy and able to manage with full dentures. However, many handicapped children, who have to be rendered edentulous, are quite unable to cope with a prosthetic device in the mouth.

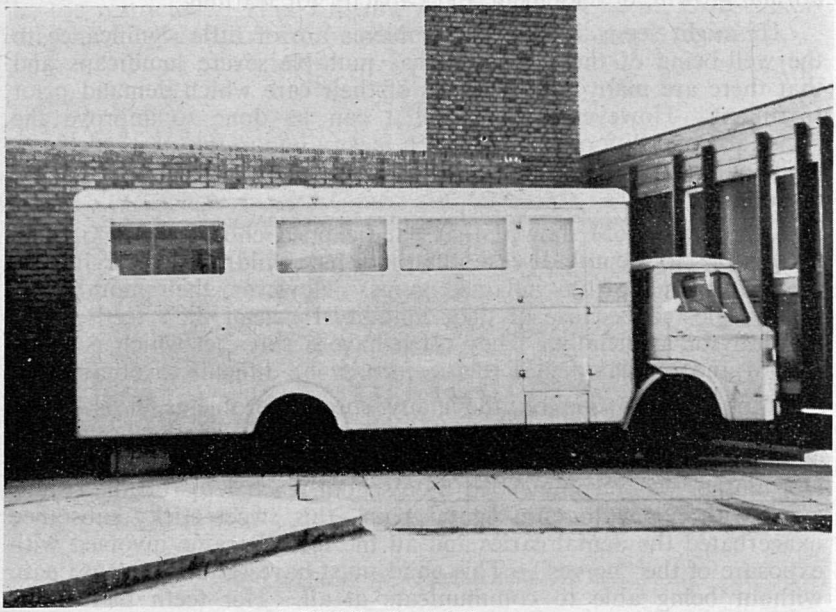
The various handicapping conditions present different problems when dental treatment is contemplated and may be considered under three main headings :—

Group I—Children for whom dental disease and its treatment constitute a special hazard.

This group includes children with congenital and acquired cardiac disease who may be at risk from oral sepsis, as the bactereamia produced by dental extraction may exacerbate their cardiac condition. The bleeding diatheses, acute and chronic respiratory disease,

should also be mentioned here, children with the former being at considerable risk with dental extraction and the latter providing problems for the anaesthetist and post-operative management. These children may well attend normal schools and would not necessarily provide any particular problems in management. Prevention of dental disease is the most important part of their treatment, because with regular dental care and co-operation from the parents, dental extractions are avoidable.

It is important that there should be a regular channel of communication from paediatrician, family doctor and school medical officer to the dentist to ensure the special attention from an early age that these children need. The social worker very often plays an important rôle in maintaining this channel of communication.



A Mobile Dental Surgery.

Group II—Those children with physical handicaps which make dental treatment difficult to obtain.

Because of their immobility it may not be possible for physically handicapped children to avail themselves of the existing dental services. This group does not usually present any particular problem in dental treatment once in the chair, although many are naturally anxious at first because of their past experience of hospitals and operations.

In the schools we visited, children with cerebral palsy provide the largest proportion of this category. In the younger age group we have treated many children with spina bifida, who survive the neonatal period due to recent advances in the surgical treatment of this condition.

Poliomyelitis and cyanotic heart disease are among the many other conditions which make up the second group.

Group III—Those children who may have difficulty in accepting dental treatment.

This group is by far the largest in our study. It includes children who are mentally handicapped and children with multiple handicaps including severe subnormality. It is interesting to note that many severely subnormal patients, particularly those with Down's syndrome, accept dental treatment under local anaesthesia quite readily once they have become used to us. The problem seems to be that many parents, because of their own fear of dentistry, have avoided taking the children to the dentist because they assume they will react badly. Unfortunately, many dentists make the same assumption, so that the only treatment they offer is extraction under general anaesthetic or referal to hospital.

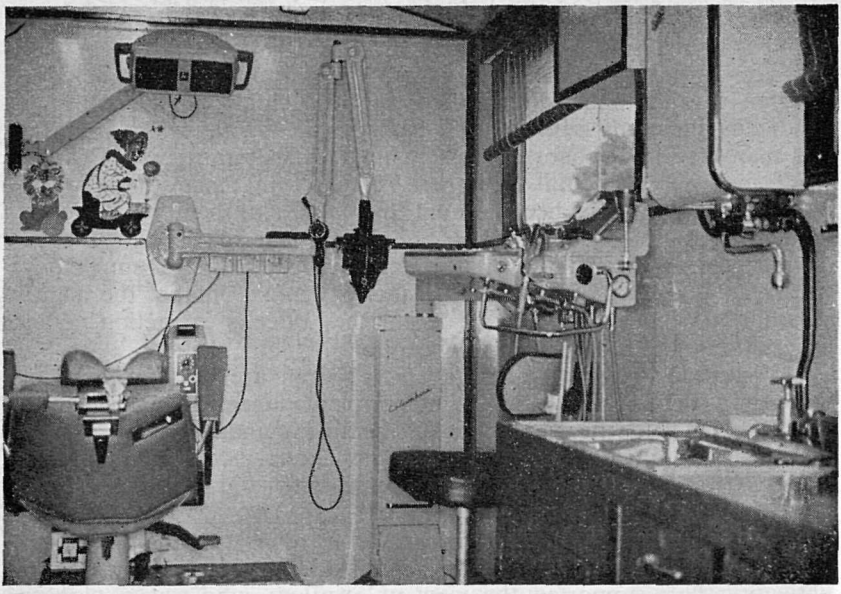
Disturbed, psychotic and autistic children are also included in this group, they present a real problem of management in the dental surgery, and some have their entire treatment under general anaesthetic. They often react badly to short spells in hospital and are usually better treated on a day-stay basis, when the mother can stay with the child.

A pilot survey involving treatment of all these groups had shown that it was possible to treat a large number of these children as outpatients. This supported the view of Swallow, who was a pioneer in the dental care of handicapped children. However, many willing dental practitioners are unable to cope with the special problems presented by these children in their own practices. There are a number who give sessions to this work either in practice or in hospitals. The local authority and hospital services are desperately short of specially trained staff. It is for this reason that final year students are being encouraged to spend an elective period in this particular work. The demand for treatment at the hospital has steadily increased. Owing to an overcrowded department with no enclosed surgery and no lift, we were forced to examine the possibilities of taking treatment to the children.

The use of a mobile surgery within the hospital grounds was contemplated, but it was not until July, 1967, that the Handicapped Children's Aid Committee came to the rescue with financial support for a purpose-built mobile dental unit. The equipment is arranged to give flexibility and the possibility of change and modification with experience. The presentation of this unit was reported in the Guy's Hospital *Gazette* in July, 1967. The continuing interest shown by the Handicapped Children's Aid Committee in the work of this unit has been a great encouragement. For some six months this unit was used near the Dental School as an additional surgery, but staffed only on a very part-time basis.

Application was made to the Department of Health, and a grant was received for three years. We have also been greatly assisted by a grant from the Spastics Society. With this financial support we have assembled our team.

It was decided to study the problems in the three London Boroughs of Southwark, Lewisham and Greenwich. It was quite



Interior of the Mobile Unit.

obvious that in a densely populated area it was a practical proposition for the mobile unit to visit nurseries, special schools and training centres in these Boroughs, and we were most grateful to the Chief Medical Officer of the Inner London Education Authority, Dr. Stewart, and the Dental Adviser, Mr. K. G. Webster, for their co-operation in obtaining the permission of their Committee to allow the unit to make these visits. The local authorities, through the good offices of the Medical Officers of Health, and their Chief Dental Officers, Mr. Cleary, Mrs. Leeming and Mr. Elston have given us wonderful co-operation.

Two objectives of this study were to determine the prevalence of dental disease amongst handicapped children attending special schools and hospitals in the area and to assess the possibilities of treatment. Standardised methods of examination were used to assess dental caries, gum disease and malformations affecting the dentition and jaws. The group consisted of 800 children aged between $1\frac{1}{2}$ and 17 years attending day nurseries, special care units and day schools, training schools and residential hospitals. After examination, the parents were informed of the findings and were invited to participate in the study by allowing their children to receive a full range of dental treatment in the mobile unit at the schools.

A programme of dental health education has been provided and a handbook for parents is being prepared. Each child has had a topical application of fluoride every four to six months as a preventive measure. Where possible, parents and children were instructed in oral hygiene at the chairside. In addition to this, lectures on prevention of dental disease have been given to the staff at the different centres.

Another objective was to study the actual equipment and methods of bringing treatment to these patients, and the unit is equipped with a hydraulic lift to give access for wheelchairs and those children who are not able to manage steps. The equipment has been modified and is as simple as possible in order to save complicated service requirements. The first winter showed up many of the problems of design, as the unit has to carry its own water supply, which is so important in a dental surgery. It also has to be supplied with adequate mains connections in order that heating, lighting and the built-in compressor can operate to allow the use of high-speed air turbines.

The logistics of this exercise are not without their amusing side. One of the primary questions was for us to decide who was to drive this unit and Mrs. Pool volunteered to undertake not only the extremely complex dental care of these children, but also to take out a heavy vehicle licence and be self-supporting when it came to moving the unit from one school to another. In designing the unit it was difficult to decide whether it should be motorised or towed. Each type of unit has its advantages and disadvantages, and discussions took place with various local authorities using both caravan and mobile units. Individual caravans are best suited where there is a central transport pool, as a number can be moved with only one towing vehicle, but in our case mobility was necessarily an important factor. Many of you will have seen this large vehicle parked in the precincts of the Dental School and may have missed the diminutive figure of one of the authors manoeuvring this through the narrow roads of the Borough and into almost inaccessible school premises. School authorities have been very kind in making access to their premises as practicable as possible, but in many cases the widening has been a little traumatic.

Results

The results have been very rewarding. It was found that all the children could be examined without much difficulty and that most of them needed some form of dental treatment. Very few of them had received adequate dental care in the past, and most of this had been carried out in hospitals. Approximately 80 per cent of the parents agreed to their children being treated in the mobile unit, but disappointingly few parents exhibited any active interest in being present for the appointments. Most of the children could be treated under local anaesthesia. On recalling the children after six months it was found that there was little need for incremental treatment for dental decay. Gum diseases, however, were persistent in some groups and it was very difficult to improve the oral hygiene, particularly for children with multiple handicaps.

A small percentage of children requiring hospital treatment present a real problem because many of them cannot be taken into wards that are unable to make special provision for nursing care, and day stay facilities are very limited. We have been very fortunate through the Dental Surgeon, the Local Management Committee and the Regional Board, to visit Goldie Leigh Hospital in Bexley. This is a

residential hospital for severely physically and mentally handicapped children. These children have been examined and treated, giving us valuable information on severely handicapped children in residential care. At the hospital we have also been able to obtain facilities for the treatment of children under general anaesthesia on day stay and in-patient basis, both from Goldie Leigh and other schools. A few selected cases have been treated by referal.

The terms of reference of this unit have been widened to include an assessment of articulatory performance and evidence of other defects in oral function. This is being carried out by Mr. Fawcus, speech therapist at the hospital.

In addition to this work in the mobile unit in the catchment area of Guy's, a member of the team has been travelling further afield to try to assess the problem of handicapped children in other parts of the country and abroad. He has discussed the services that are already available and the setting up of new centres.

Lectures and symposia have been given to many groups sponsored by the British Dental Association, the Postgraduate Medical Federation, Voluntary societies for the care of the handicapped and the Royal College of Surgeons. Visitors from home and overseas have come to observe and discuss the problems of running this type of unit.

In conclusion it is important to stress that this project could not succeed without the help of many supporting staff.

We would also like to extend our thanks to the teachers in the various schools and training centres and the staff of Goldie Leigh Hospital, without whose co-operation we would have found our task much more difficult. We would also like to thank the maintenance staff of Guy's Hospital Dental School for the technical help which they have given in their spare time to keep the equipment in order; the Handicapped Children's Aid Committee for their generosity in providing the unit in the first place; the Spastics Society and the Research Division of the Department of Health. Finally we would like once again to thank the Chief Dental Officers of the Boroughs of Southwark, Greenwich and Lewisham for their very active co-operation.

NURSING SECTION

Weekend Working

It has always been understood that if one elects to follow nursing as a career, there will be a necessity to work at weekends and on Bank Holidays. In lieu of this, nurses have far more holiday than any other sector of the working public. Even the doctors are not at an advantage in this respect.

Unfortunately, however, despite these facts, there seems to be an increasing reluctance by nurses to fulfil their obligations, particularly those who are in training. Absenteeism on Sundays is becoming as much of a problem in hospitals as in the factories on New Year's Day.

Since this strange and rather saddening lack of responsibility appears to be in our midst on an ever-widening scale, it might be worth considering why this should have arisen over recent years.

Ten years ago there was no difficulty in this way. Why then should it now have reached such grave proportions? Over that time, nurses have, to a large degree become emancipated. They have much more free time, and many more are non-resident at a much earlier stage.

There are several reasons that could possibly be used as an argument. It is difficult to ascertain which of these is in fact the correct one. Indeed, it might be a combination of any of them.

Firstly, there is the question of non-residency at a much earlier stage. Frequently the nurses share flats with friends who are never required to work at the weekend. If one has free time during the week it is evident that it will not be possible to see as much of one's "flat-mates" as is desirable. Does the temptation then prove too much, thus causing the sudden prostrating attack of tonsillitis on Sunday morning at 11 a.m.?

Another reason could be that there is jealousy of the trained staff. Most hospitals adopt a system of giving alternate free weekends to these people. It has been generally accepted over the years that this is something that comes with qualification. However, recently this is very much begrudged to trained staff by the students. They seem to forget that it is always the Staff nurses and Sisters who work long hours overtime in order that they leave the ward promptly. In addition, the trained staff are there for a much longer time than the three years training period. Also why should a Ward Sister be blackmailed into giving a weekend off to a student nurse who arrives on the ward and announces that her holiday commences on Monday, and she has booked her flight for 10 p.m. on Friday? If nurses during their training had, as an exercise, to work out a Ward off-duty rota they would probably have different views on the matter.

An interesting factor about all this is that the absenteeism is usually on Sunday and not Saturday. What part have the evening revels of the latter to play in this?

It is disappointing that nurses should elect to behave in this way. If they were doctors they would not be able to walk out at the end of an eight-hour shift. They would frequently work sixteen or eighteen hours at a stretch. Do they fondly consider that their senior colleagues are not alive to what is happening? Unfortunately, what they have forgotten is the bad feeling incurred. Any nurse nowadays who telephones to say she is unwell is not believed. Unfortunately, Ward Sisters have become so sceptical that the student has to be "in extremis" before any sympathy will be aroused. If they were only aware of the comments passed after the receiver is put down, they would probably be most indignant. However, until they as a body adopt a more responsible attitude they will find suspicion of their motives abound.

Wrist Cutting

"The Guilt is Mine, The Cleansing Blood is Thine"

Miss J., an attractive 21-year-old student, made a superficial cut on her wrist with a razor blade. She rang her bell and told the nurse. The nurse was distressed, the patient felt better. The nurse expressed pre-occupation with guilt that she had allowed the event to occur. The patient expressed relief of tension arising out of, and following the cutting.

The next day—wrist cutting being contagious—Miss E., a 19-year-old secretary, scratched her wrist with a piece of broken glass. The patient was apologetic, the nurse was angry.

Why do nurses feel distressed, and in particular, guilty when one of their patients acts in this way? They participate in assisting with surgery, and feel no guilt in the resulting injury.

Why do patients in hospital inflict superficial cuts on their wrists? An over-simplified answer might be that this is a common and copied, although unacceptable, non-verbal method of communicating distress and asking for help.

Do nurses feel guilty because they do not know how to answer non-verbal questions? Should more attention be paid to teaching them how to reply to a patient's unspoken queries?

In verbal communication an aggressive comment may receive an aggressive reply. In non-verbal communication it is likely that the same thing may happen. Wrist cutting is an aggressive act.

How should a nurse respond to a patient who has cut her wrist? Apart from attending to any necessary first aid measures, attention must be paid to distress. Efforts should be made to encourage the patient to communicate in a more acceptable way in the future. The patient should not be made to feel rejected, but enabled to feel more secure. Anxiety on the part of the nurse leads to insecurity on the part of the patient, which in turn leads to the likelihood of repetition of the act.

A patient's cry for help should receive an answer. That answer should not involve distress to a nurse.

ANN V. MOSS

BOOK REVIEWS

INFANT FEEDING AND FEEDING DIFFICULTIES.

Ronald MacKeith and Christopher Wood. J. and A. Churchill, 1971. Price £2.25.

This is the fourth edition of a book first published from Guy's in 1951 by Dr. P. R. Evans and Dr. R. C. MacKeith. It has now been substantially revised, but retains the distinctive and enjoyable style of the previous editions.

For some years there has been a reluctance on the part of children's doctors to take much interest in the problems of feeding small infants. The incidence of gastroenteritis has fallen and malnutrition is no longer a problem in our community; it might be thought that the management of infant feeding could be safely left to the health visitor, grandmothers, women's magazines or advertising agencies. However, there is evidence that present feeding practices are unsatisfactory; for instance, in some parts of the country the majority of infants are frankly obese by the end of their first year of life, and it is now known that this predisposes to obesity in later life, with all the attendant hazards. It needs to be realised that the fat bouncing baby does not necessarily represent the ideal standard for health, and it is the responsibility of all who deal with children to re-examine the advice they offer about feeding. This book offers a concise, well-researched, easily read, entertaining discussion of the whole topic and is remarkable in that all students of medicine, be they general practitioners, paediatricians, doctors in training, nurses or health visitors will find it of value. All aspects of infant feeding are considered, breast or bottle, calorie requirements, digestive physiology, feeding problems and intravenous feeding. Dr. Brian Wharton contributes an excellent chapter on protein-calorie deficiency syndromes and considers the feeding problems encountered in developing countries. The advice offered is good because it is simple, practical and easily understood, and therefore likely to be more readily acceptable to the majority of mothers.

More could have been made of the dangers of failing to make up powdered cow's milk correctly. A recent study showed that the majority of mothers tend to make these feeds too concentrated; not only does this lead to obesity, but the mineral content of the feed is also increased. If extra water losses occur from diarrhoea and vomiting, dangerous hypernatraemia can and does occur, and is being seen more frequently in children's hospitals throughout the country. A larger discussion within this context of the mineral content of cow's milk as opposed to human milk, and what it means to the small infant would be helpful in the next edition.

The book is reasonably priced, the illustrations are well chosen, and it is strongly recommended to any who intend to offer advice about how their own or other people's children should be fed.

CYRIL CHANTLER.

THE BRITISH RED CROSS IN ACTION.

Dame Beryl Oliver, G.B.E., R.R.C. and Faber & Faber, £3.15.

In all that concerned the British Red Cross in the period 1937-1946, Dame Beryl Oliver's name was a household word. She has written a comprehensive and masterly report of the work of the B.R.C.S. on active service in all spheres of the war, and, in addition, of the complicated problems concerned with the comfort and care of the about-to-be repatriated prisoners of war.

But the early part of her book reaches back to the Crimean War and earlier. Chapters IV and V tell of the determined and inspired work of General Dunant in the face of many difficulties. He first brought to the attention of Crowned Heads, Governors, Diplomats and others the neglected plight of the wounded and sick in the aftermath of war. At last, the International Conference of Societies for "Aid to wounded soldiers in time of war" was planned to meet in Paris in August, 1867, but, by this time, General Dunant was exhausted, bankrupt and disgraced. The old story repeats itself. The prime movers of any great cause being neglected and sacrificed. In this case, General Dunant, the mover and founder of the International Red Cross, was humiliated, denied the right to call himself a citizen of his native city, Geneva, and finished his days in poverty.

In the South African War the embryo of a combined society, the British Red Cross and the St. John Ambulance Brigade, was stirring in its infancy. Great and far reaching developments ensued. Much research has gone into Dame Beryl's work and there is a fine bibliography. This is a book to read and re-read and to own. E.P.M.

CORRESPONDENCE

Bermondsey's Backstairs

THE WILLS LIBRARY
JUL 1971
HOSPITAL

SIR,—In appreciation of the Glittering Tower.

Roll up the asphalt carpet with slum bows.
Put a match to the boot-black mascara tears
That fall down Bermondsey's backstairs.
Explode sentimentality and let grasses grow
On the ashes of Societies' Modern Years,
Where no Tower of Babel divides the sky
That has a punch-clock only in the sun.
Freedom is the grass, the rest is a lie.
For where Men walk it matters not
If there is an asphalt path or grass.
The Mind is the same and only sees
Self-survival as the real knot
That holds the grass beneath his feet.
Cleverness grows with the exploitation of the ties
Of weaker minds that believe the lie
That Man is free and really can greet
The growing grass, a symbol of their belief.
But where was the cry when the asphalt tide
Burnt the grass and built Babel's Tower
As an excuse? Only gravestones are their grief.
White tongues that cannot move to speak,
To shout, "It matters not what the Planner's Books tell,
Each Mind is locked in its own selfish cell".
And those that now try to scrape through the walls,
Crying for a new type of freedom for all,
In the end, even with the pattern of Freedom won,
Have to organise it in a Communal Life.
How then can Freedom be free if organised?
Roll up the asphalt carpet and let the grass grow,
Burn Man to ashes, then Freedom will blow
Through no Slums, with only grass eyelashed eyes to stare,
At the end of Man's Cruelty on Bermondsey backstairs.

Yours faithfully,

B. WOTTON.

Frangipani,
West Hill,
Heybrook Bay,
Nr. Plymouth.

MR. GUY'S HOSPITAL

In 1954, "Mr. Guy's Hospital" was published. This book was sponsored by the Board of Governors and written by Dr. Hector Cameron, a former Dean of the Medical School and Children's Physician, who retired from the active staff in 1945 and spent his later years as a writer of no little merit.

The book, when it was published, was regarded as an authoritative, well-balanced account of the life of Guy himself and of the history of the Hospital which he founded as well as of its Medical and Dental Schools. It took into account a wealth of original material which had not been available to the earlier standard history by Wilks and Bettany, and is an indispensable background to those who have a real interest in the beginnings and history of this institution. It is attractively printed and liberally illustrated with a number of plates.

This book is no longer available through the normal trade channels, but a number of copies are still held by the Hospital. These are available for sale from **The Cashier, Counting House, Guy's Hospital, London, S.E.1,** price £1.15 (including 25p packing and postage)—cash with order, please) or 90p on personal application. Any readers of the "Gazette" who are interested in obtaining a copy, are urged to make application as soon as possible to avoid disappointment.

SPORT

BOAT CLUB REGATTA

Sunday, 13th June, 1971.

This year the regatta was organised on a Sunday to accommodate two members of the club who have had heavy open regatta commitments, and who were also selected to trial for the 1972 Munich Olympics. Despite the magnanimity of this decision, and a very heavily rigged draw, these two—Paul Stuart Bennett and Tony Fenn—successfully monopolised the open events.

In the open sculls, Stuart Bennett made short work of his opposition, and won the silver sculls, which have only been awarded twice since they were lost in 1864. In the only other event for which trophies were presented, Stuart Bennett and Fenn, rowing a coxless pair, obviously derived great enjoyment from watching crews struggling in their wake, even if their interpretation of the meaning of "neutral water" was not a conventional one. The umpire for the final distinguished himself by assuming at the start, that a raised hand meant that a member of a crew wished to leave his boat, and in consequence, insisted on dispatching both crews in the direction of the boathouse with the greatest alacrity. Nine members of the 1st VIII squad took part in the event, the number being rounded up by our tenth or adopted spare man and University boatman, Jim Wallis, whose tolerance of our efforts knows no bounds.

The focal point of the morning was the launching of our new eight—"Frank W. Law"—by Mrs. Mansie. The christening of the boat was carried out in the presence of Mr. Law and Mr. Mansie, the President. Mr. Law has kindly given permission for his coat of arms to be added to the name-plate of the boat.

The eight is five feet shorter than a conventional boat, and is built for a 12-stone crew. It has the latest slides, and riggers, which are adjustable in all dimensions. Even to an inexperienced eye, she is a beautiful boat, well finished in a fairly square section, so that properly used and tuned, she is going to be one of the fastest boats in the U.L. boathouse. The comments of the crew that rowed her (which included the Oxford London marathon oarsmen who regard her with particular pride), ranged from: "She goes like a bird, and sits and runs so sweetly" to "We would have had Mary's with this".

In the only event for fours, all those present had been invited to pool their names for a draw. In this manner, five crews were formulated, and there was considerable delight when some crews found that their boats were to be graced by the ladies of the Boat Club. The latter were careful to inform their counterparts, that they had been training over a six-minute course in preparation for the event. No doubt the shorter course upset them, because, despite great efforts and some exciting racing, the winners were found, after critical examination, to be an all-male crew, as their half-drowned cox later recounted.

The ladies' reputations as oarswomen were not only retained, but also considerably enhanced by Fiona Odle in the novice sculls, who not only gained on her opponent, but almost succeeded in cutting his boat in two as she made an early run for the bank. This event showed the largest numerical entry, and some very striking displays of watermanship were given, although the club is known to be insured for such eventualities. British Rail are not thought to be making a claim for their bridge.

If there had been more time, there is no doubt that an even greater number of races might have taken place, but the Sunday time limit did not appear to detract from the enjoyment of the event, and the brilliant sunshine quite certainly enhanced it.

Results.

Open Sculls—P. Stuart Bennett.

Open Pairs—A. Fenn, P. Stuart Bennett.

Novice Sculls—P. Stevenson-Moore.

Captain's IV's—Bow, J. Monson, 2 M. Wink, 3 P. Robinson, Stroke P. Hunt, Cox R. Ashman.

TABLE-TENNIS

CHAMPIONSHIP (HANDICAP) OF GUY'S

Kenneth Wang has yet again taken the Guy's singles title, but only just. Twice he pulled himself up from being behind to clinch the championship.

Approximately thirty took part in the championship, and the first interesting match came in the second round, when Paul Coley defeated the new mixed doubles champion, Liz Thomas, by 21—16, 19—21, 21—19. Next came the big surprise when the ladies' champion, Fiona Odle, overpowered one of the top Guy's players, T. Jarvis, by 21—15, 18—21, 21—14.

Giles Rowntree had a hard match against up and coming Nigel Clark before winning 21—11, 19—21, 21—16. Steve Willis, Alan Greenwood, Calvin Wang and Kenneth Wang came through without too much trouble, although Alan had a hard time with top nurse, Marilyn Edney, before winning 21—16, 21—19.

Unfortunately Giles had to leave, and could not get back in time for his match against the champion, Kenneth, who reached the semi-final, as did Steve. Calvin, who easily beat Paul Coley, and Alan, who had a rather easy match against Fiona.

In the semi-final, Kenneth, the champion, ran into deep water against Steve, who played consistently, and was leading 20—17 before his concentration cracked and he lost the first set 24—22. Back came Steve, who completely demoralised the champion in the second set and won 21—11. This continued at the start of the final set, but Kenneth completely changed his game, and inaccuracies started flying from Steve's bat, and Ken clinched the match 21—17, after one of the hardest matches he has ever had at Guy's.

Alan, too, put up a stiff resistance against Calvin before the latter came through in two sets. Alan is Guy's big hope for next year. He has improved tremendously during 1971, and could well be challenging for the title in 1972.

The final was most spectacular with first Kenneth dominating, then Calvin, before Kenneth took his fourth singles title by winning 21—18, 13—21, 22—20.

Kenneth Wang is therefore still champion, but his position was seriously threatened by Steve Willis and Calvin Wang. Fiona Odle still proved her superiority in the women's class, while it seems that Marilyn Edney would be her greatest threat. We look forward with interest to the next championship in November.

CHRIS. WILLIS.

TABLE-TENNIS MATCHES—U.L.U. LEAGUE

1st Team—Division 2.

Guy's I—U.C. 11: 7—3.
I.C. III—Guy's I: 0—10.
Thames II—Guy's I: 4—6.
Guy's I—I.C. II: 6—4.
Guy's I—Q.M.C. II: 9—1.

Guy's won Division 2 outright and will next year be in Division I for the first time in their history. Congratulations to R. Wang, C. Wang, S. Willis, N. Harradine, C. Willis and A. Greenwood, who helped us to gain this notable success.

2nd Team—Division 3.

Guy's II—I.C. IV: 10—0.
Guy's II—London Hospital: 10—0.
Royal Holloway—Guy's II: 0—10.
Guy's II—Chelsea II: 10—0.
Thames III—Guy's II: 1—9.
Q.E.C. II—Guy's II: 10—0 (Guy's had to scratch in this match).

Guy's second team tied first with ten points, but due to the fact that we could not get a team up against Q.E.C. II, we were pushed into second place on games average because we had to lose 10—0. Before that match the team had won 49 games for the loss of only one. This performance has earned our second team a place in Division 2 next year.

As one of the best seasons of table-tennis in the history of Guy's draws to a close, we can now summarise the honours achieved by the students.

Men's Singles.
1, Kenneth Wang; 2, Calvin Wang; 3, Steve Willis; 4, Chris. Willis.

Ladies' Singles.
1, Fiona Odle; 2, Elizabeth Ryman; 3, Jill Harris; 4, Ann Rothman.

Ladies' Doubles.
1, Elizabeth Ryman, Caroline Rix; 2, Ann Rothman, Sheila Owen.

Mixed Doubles.
1, Elizabeth Thomas, Steve Willis; 2, Elizabeth Ryman, Chris. Willis.

Handicap Tournament.
1, Kenneth Wang; 2, Calvin Wang; 3, Steve Willis; 4, Alan Greenwood.

Leading Fresher.
Alan Greenwood.

A total of 115 participants took part in our five tournaments.

This has really been a season worth remembering. In one short year we have become a leading force in London University. Our ultimate aim next year is to go for the greatest prize of all, the Division I title. We have the players to achieve this. I would like to take this opportunity to thank all those players concerned, who helped to make Guy's a strong table-tennis force.

STEVE WILLIS.

TABLE TENNIS

The annual Students versus Mr. Pringle's team match began for most of the latter team at 5.30 p.m. on 24th May with their annual practice. The match started at 6.0 p.m. Mr. Pringle had brought along three regular stars in Dr. Osborn, Dr. Ivanyi and Miss P. Henley. Three new performers were Mr. Challacombe, Dr. Paddle and Miss K. Henley, who provided attractive support for her renowned sister. For the "A" team, the Willis brothers won all their matches, although they both heaved visible sighs of relief on sealing their victories against Miss Henley. Dr. Osborn, even more starved of practice than usual, never quite established his usual formidable steadiness against these two, just failing to win a set in both matches. Claudia Roe gallantly succumbed to all three opponents, who in turn conceded overall victory by seven games to three.

Team "B" found Nigel Harradine tottering in for his fourth appearance in this event and sneaking three victories, managing to avoid the full wrath of Dr. Ivanyi's fearsome forehand in doing so. Fiona Marsh gained a valuable victory over Miss K. Henley in a feast of long, neck-stiffening rallies. Dr. Ivanyi once again proved too strong for all her female opposition, although Jill Harris pushed her to her top game throughout. Jill then outlasted Steve Challacombe for a famous victory, and triumphed in her last singles and the mixed doubles. Everyone enjoyed the evening, including a few very partisan spectators who shared in the very necessary refreshments provided by Mr. Pringle. Mr. Pringle is to be congratulated on raising his team, and it is hoped that next year the male staff and female students may provide stiffer competition for their opponents of the same sex.

SPORTS DAY

Saturday, 19th June, 1971. H.O.P.

After a disastrously wet fortnight, the sky relented for long enough to hold the first Sports Day for two years on a very boggy track at H.O.P. It was perhaps understandable that so few turned up on the day to enjoy themselves. It should be emphasised that the aim of the organisers was "audience participation" by all, but strangely, an inordinate amount of persuasion had to be used on steadily drinking spectators in order to fill the events.

This year we decided to cut down the number of serious events on the day to five, thus making room for further "more enjoyable" events. The winner of the Victor Ludorum Cup was Kevin Sheppard, who narrowly beat R. Yetton (Angels) and R. Nicholls by one point. The 120 yards hurdles was won in 17.2 secs. by M. Avery; the 100 yards by R. Nicholl; the 880 yards by B. Jones in 2 mins. 8 secs.; the shot by K. Sheppard; and the long jump by Rex Yetton with 19ft. 3ins.

Other notable performances came from two very game registrars, Dr. McGill in the long jump (7th), and Mr. J. Harding in the shot (2nd).

Some of the more light-hearted events were won by various combinations of males and females, notably the wheelbarrow race, when the male half was heard to say after being the wheelbarrow: "That was worse than 100 press-ups!"

The residents' 100 yards was very badly supported despite suitable liquid bribes, but the Consultants' and Registrars' walk provided great amusement. Dr. Knight fought off strong challenges from Drs. Tomkinson, Cameron and McLean, to win his bottle of sherry; while Dr. McGill carried off the Registrars' prize from Mr. Harding and Mr. Poole. Due to the state of the track and a facing wind, no records were broken in this event.

The mainstay of the programme was undoubtedly the contest against the Angels, who notched yet another victory over an established club. They won the chariot race, shot and tug-of-war cup (2—1) to carry off 21 pints of beer prizes. However, they failed to beat a well-trained scratch athletic club team in the beer race.

The Ward relays provided much fun for a large number of people, but surprisingly few of the nurses in the crowd volunteered to run. However, Evelyn Astley-Cooper, Addison, Steven and Sarah Wards competed together with the Medical Secretaries and a pseudo-Dental School team.

The last-mentioned had found the secret of winning and fielded a University lady runner, thus winning both their heat and final. The famous bed-pan trophy, originally awarded to the wards, has now gone over the park to that other building.

We were very honoured to have Mrs. McLean, wife of Dr. McLean, to present the prizes, most of which seemed to go to the Angels, who were most unjustly accused of rigging the tombola.

The side-shows are as much a part of Sports Day as the events themselves, and it was with this in mind that John and Kate Shutes tackled the difficult problem of running the money-making part of the day. Without their untiring efforts, Sports Day would have been very much poorer, both in quality and financially. Our thanks go to the willing band of helpers at the stalls, too. Beryl Way and her happy band supplied and sold a large number of strawberry teas, a new feature of recent sports days. They, too, put in a tremendous amount of work.

Finally, we would like to thank our President, Mr. Tomkinson, for his enthusiastic support throughout the afternoon.

CRICKET

2nd XI

Match v. King's

It was decided that it was about time that the 2nd's had a win, and so a much changed side was fielded for the opening Cup match against King's (one has to change a side around to even find eleven people, to play on a Monday afternoon).

The ground was like a meadow (they forgot to mow the outfield), but a wicket had been thoughtfully provided. The Guy's gentlemen cut dashing figures in their all-white strips, offset by the bright greens, reds and blues of the opposition—already a moral victory.

The toss was lost and King's elected to bat on a perfect bowling wicket, which was drying in the sun. The bowlers kept the wicket-keeper at full stretch, but, thanks to three straight full tosses from Skinner and a fine bowling debut by Dave (four wickets), Jones, King's were all out for 93 runs after two hours of wides, no balls and the very occasional bye.

A stand by Scoble and Standish put Guy's on top until the inevitable collapse. With the score at 76—9, all seemed lost, but Young in a flurry of big hitting, saved the match. This was an obvious irritation to the King's side, which displayed its feelings throughout the match.

HOSPITAL INFORMATION

GUY'S HOSPITAL
HOUSE APPOINTMENTS
1st September, 1971

Applications are invited for the following *house appointments due to begin on* 1st September, 1971. Forms of application are obtainable from and should be returned to Mrs. Webster, Administrative assistant for Medical Staffing, Counting House, not later than **23rd July, 1971.**

The following house appointments will be for six months and normally will be open only to pre-registration candidates *applying for their* first appointment and not to candidates seeking their second six months' appointment.

House Physicians 4
House Surgeons 4
Throat and Ear House Surgeon 1
Orthopaedic House Surgeons 2
(The successful applicants will be required to spend six weeks at New Cross Hospital)
Gynaecological House Surgeon 1

The following house appointments will be *for six months and will be open to candidates* who have already completed their first six months' appointment at Guy's or elsewhere:—

House Physician 1
House Surgeon 1
Childrens' House Physician 1
Genito-Urinary House Surgeon 1
(or post-registration)

The following post-registration and S.H.O. appointments will be for six months:—

Resident Obstetrician (S.H.O.) 1
Casualty Officers (S.H.O.) 4
Neurological House Physician 1
(Post registration)
Resident Anaesthetists (S.H.O.) 2
Senior House Officer to Nuffield House (S.H.O.) 1
Dermatological House Physician 1
(Post registration)
Senior House Officer to the Renal and *Transplant Units* (S.H.O.) 1
House Physician in Child Psychiatry .. 1
(Post registration)
Senior House Officer to the Thoracic Unit (S.H.O.) 1
House Physicians in the Dept. of Psychological Medicine (S.H.O.) to commence 1.10.71. 2

EVELINA HOSPITAL
Children's House Physician 1
(Post registration) to commence 1.10.71.
Casualty Officer (S.H.O.) 1
(part-time, six mornings a week)

ST. OLAVE'S HOSPITAL
House Physician (pre-registration) 1
Preference given to second 6 months' candidate but first 6 months' candidates may apply.
Gynaecological House Surgeon (S.H.O.) .. 1
House Physician in the Dept. of Psychological *Medicine* (S.H.O.) 1

NEW CROSS HOSPITAL
House Physician in General Medicine and Geriatrics (pre-registration) 1
Preference given to second 6 months' candidate but first 6 months' candidates may apply).

OUTER HOSPITALS
Preference will be given to second 6 months' candidates for the following posts, but first 6 *months'* candidates may apply.

BECKENHAM HOSPITAL
House Surgeon to Mr. C. Cookson, Mr. D. I. R. Higton and Mr. C. L. Kinder 1
House Physician to Dr. C. Joiner and Dr. K. O. Rawlings 1

GREENWICH DISTRICT HOSPITAL
(married accommodation available)
House Physician to Dr. R. H. R. Hartley, Dr. E. T. Bassadone, and Dr. C. N. Mallinson 1
House Surgeon to Mr. J. Candy and Mr. M. C. Eldin 1

HITHER GREEN HOSPITAL
***House Physician to Dr. Blackledge and* Dr. Llewellyn Smith** 1

LEWISHAM HOSPITAL
House Surgeon to Mr. Le Brun 1
House Surgeon to Mr. Cavendish 1
House Physician to Dr. Llewellyn Smith .. 1

ORPINGTON HOSPITAL
House Surgeon with Ophthalmology to Mr. Walker-Brash and Mr. Chivers .. 1

PEMBURY HOSPITAL

House Surgeon (pre-registration) 1
House Physician (pre-registration) 1

ST. HELEN'S HOSPITAL, HASTINGS

House Physician in Geriatrics and General Medicine to Dr. R. Irvine
(pre-registration) 1

P. J. HELLIWELL,
Superintendent.

June, 1971.

The following Dental House Surgeon Appointments have been made for the period 15th July, 1971 to 14th January, 1972:

General Duties
Mr. K. P. J. Malone
Mr. J. C. Beckerson
Mr. C. H. Ballard
Mr. E. P. Brown
Mr. J. A. Williams

General Duties Resident
Mr. P. R. Hunt
Mr. J. C. Miller

General Duties with Oral Surgery
Mr. P. S. Richardson

Prosthetics Department
Mrs. M. Smith

Dental Department for Children
Mr. W. F. Haines
Mr. D. J. McConnell

P. J. HELLIWELL,
Superintendent.

18th June, 1971.

PASS LIST

CHARTERED SOCIETY OF PHYSIOTHERAPY

Final

Miss S. G. Butler
Miss W. R. Gibson
Miss J. M. Kelly
Miss V. A. Lockhart
Miss J. Roubicek
Miss J. E. Thompson
Miss B. A. Thurlow
Miss C. D. Watt

Intermediate

Miss C. E. R. Arnold
Miss D. J. Beauchamp (Credit)
Miss R. J. Chamberlain
Miss A. E. Clooney
Miss V. M. C. Davidson
Mrs. D. S. Dear
Miss B. K. Dooley
Miss J. E. Fisk
Miss M. L. Frisby
Miss S. Gray
Miss P. I. James
Miss H. R. Matthews
Mrs. E. J. McAllister
Miss C. A. Meadows
Miss J. Miles
Miss J. Osmond
Miss S. S. Pettersen
Miss V. M. L. Philps
Miss J. B. Rasdall
Miss J. E. Sheffrin

Preliminary

Miss P. J. Aste
Miss J. F. Barton
Miss S. A. Edwards
Miss B. B. Goldsworthy
Miss T. J Hamblin
Miss C. E. M. Jackson
Miss D. G. Manwaring
Miss E. V. Pote
Miss A. F. Schott
Miss L. R. Stock
Miss H. W. Strange
Miss G. J. Sykes
Miss A. Webster
Miss N. S. Wells

SCHOOL OF DENTAL HYGIENE

Certificate of Proficiency

March 1970
Christine Barnard
Sheila Chapman
Sally Hooper
Verity Lorimer
Susan Redford

June 1970
Julie Kanas

March 1971
Ann Adamson
Patricia Gooderham
Christine Green
Janette Withers

June 1971
Candida Walker

PERSONAL

H. F. A. Baker, Esq., L.D.S., 14, Park Lane, Wallington, Surrey.

DEATH

JONES—On 16th May, 1971, at the Caernarvon and Anglesey General Hospital, Bangor, Dr. Idris Oliver Jones, qualified Guy's, late 1920-30.

PAPER BY GUY'S MEN

Stewart, I. McD. G., "Long Term Observations on High Blood-pressure Presenting in Fit Young Men." *Lancet* 1971, **1**, 355.

We would like to remind our readers that all copy for inclusion in the "Gazette" must be received eight days before publication date.

Copy may be sent to us c/o The Front Lodge, Guy's Hospital.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, please indicate whether or not this should be published.

Personal notices 5p per word (pre-paid) (minimum £1.05).
Non-subscribers will pay £1.05 (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

EDITORS N. D. S. BAX and A. M. TURNER
NEWS EDITORS R. M. DARLING and J. L. LEWIS
SPORTS CORRESPONDENT A. M. ROYSTON
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TEN PENCE VOLUME 85 NUMBER 2165

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

It's a Sizzler

Phew, what a scorcher or, as they say in Fleet Street, it has been uncommonly warm this week. In Britain over the past decade we have seen an acceptance by the companies who provide power for cooking and heating that during the coldest days in winter people need more heat than at other times, so we are now equipped to deal with winter's hitherto unexpected properties. Gone are the days of warming and lighting the whole family with three Christmas cake candles apart from when the employees of the power companies need more money, paradoxically. But we still have not adjusted mentally to the unexpected properties of summer.

It would be unimportant if the only misfortune we suffered was the fear of a judge's intolerance because we did not wear a tie in court, or the cost of an extra can of anti-perspirant. That, unfortunately, is not the sum of our suffering from ignorance of what behavioural changes to make in the occasional summer heat. Many people have no idea that babies left alone in cars in hot weather are liable to die, even if left for what seems to the parents a short time. In most cases when that happens the parents have no wilful intentions, they do not know or forget that a tiny wrapped baby has special problems with temperature regulation. Animals even are better treated in this respect; a panting, obviously hot dog in a car is always allowed an air ventilation. But then that reflects part of the English obsession with pet dogs: it is said that Descartes' physical theories of gravitation never carried much weight in England because he also pronounced that dogs had no soul.

Nevertheless, the claimed ignorance about the dangers of overheating babies must be dispelled. Recently the newspapers have reported in little paragraphs at the bottom of an inner page that police have had to break into cars to save babies. The procedure they then follow can be quietly to prosecute or allow the N.S.P.C.C. to bring charges against the parents or those with an especially responsible relationship with the child for negligence. Such action

will never educate. A poster advertising campaign conducted either by the police or the N.S.P.C.C. is urgently required.

It is possible that the heat of this summer has passed. We can never tell since the forecasts are of little value; the heat wave of this July was missed, it was probably mixed up with the files for stories about next year's weather. A campaign should be launched now so that when the heat comes, people will understand how to look after their babies.

Front Surgery

For the third time during the consultant's round the bleep goes and one's imagination is not greatly taxed to know that it is casualty requiring suturing to be done. Such has become one of the "duties" of being on surgical take-in. Infuriating and educationally useless. However, if the take-in student does not go and suture, the patient will have an equally infuriating wait. Why is it that front-surgery has become such an unpopular activity?

Theoretically, front-surgery offers the student the opportunity of being the first person to see and diagnose conditions in people who need emergency treatment. In reality this is far from the truth. The student does usually see the patient first, but more and more of the patients do not require urgent attention and could in no sense be classified as an emergency. Many of these patients could have been dealt with by their general practitioner. Why patients by-pass what the medical service considers to be the accepted channels of advice is yet another problem, but with Guy's Emergency and Accident department a disproportionately important one. In many respects our casualty department functions merely as a large general practice.

Those who are employed by the hospital in the emergency and accident department may say, and some do, that the failure of students to attend is due to the latter's "apathy". But why should students be apathetic? It is not due to a fall off in material to see, for patient attendance numbers have remained stable at around the 60,000 per year mark for the last five years. It may be due to examinations and this of late has been an important contributory factor. It may be due to ward rounds. Nobody seems quite sure as to which rounds, if any, take priority over front-surgery. One often mentioned the cause of the tedium of front-surgery is the inconsistency and sometimes total lack of teaching. To act in some cases literally as a scribe seems to reflect the lack of usefulness with which students are at times regarded. This factor does nothing to strengthen what should be a system of mutual help, and combined with the uncertainties of what takes priority over front-surgery only leads, perhaps at times unreasonably, to students not attending.

Finding a solution is difficult. The planned change of front-surgery training from the senior surgical firm to the orthopaedic firm is a good idea. Some favour the idea of a casualty appointment in which a student would spend a week or so of a surgical firm doing only casualty work. Whatever the eventual outcome these must be an appreciation by some students of their responsibilities and the standard of teaching must improve. In some cases teaching must start.

NEWS IN BRIEF

Ludwig Wittgenstein

A plaque has recently been erected in a corridor near the dispensary, to commemorate Ludwig Wittgenstein (1889—1953), one of the foremost philosophers of this century, who worked at Guy's during 1942-43.

Congratulations

Mr. R. G. Notley, who qualified from Guy's in 1959, is to be congratulated on his appointment as consultant urologist to the Guildford and Haslemere Group of Hospitals.

Guy's Envoy to the U.S.A.

Dr. M. A. Simpson, Psychiatry Registrar at Guy's Hospital, has been selected as one of six young British doctors to take part in a study tour in the United States of America, sponsored by the Duke Endowment and the King's Fund. The group will visit America in October—November, 1971, to study the delivery and organisation of health care in the U.S.A.

A New Manager

A new post has been created in the hospital management: Deputy Hospital Secretary (Patient Services). Mr. J. P. Curley, at present with the London Undergraduate and Postgraduate Teaching Hospitals Management Services Unit, has been appointed to the post, and will start on 26th July.

Mr. Curley will be responsible to the Hospital Secretary for the departments of the hospital dealing with the immediate "comings and goings" of patients, such as Out-Patients, Casualty, etc. An Out-patients' Officer is also to be appointed, who will himself be directly responsible to Mr. Curley.

The aim of the creation of this new post is to strengthen the middle band of hospital management. It is hoped that it will speed up decision-making, by ensuring that decisions in these departments are not taken at an unnecessary high level.

The new managerial structure has been agreed by the Board of Governors.

War on Want

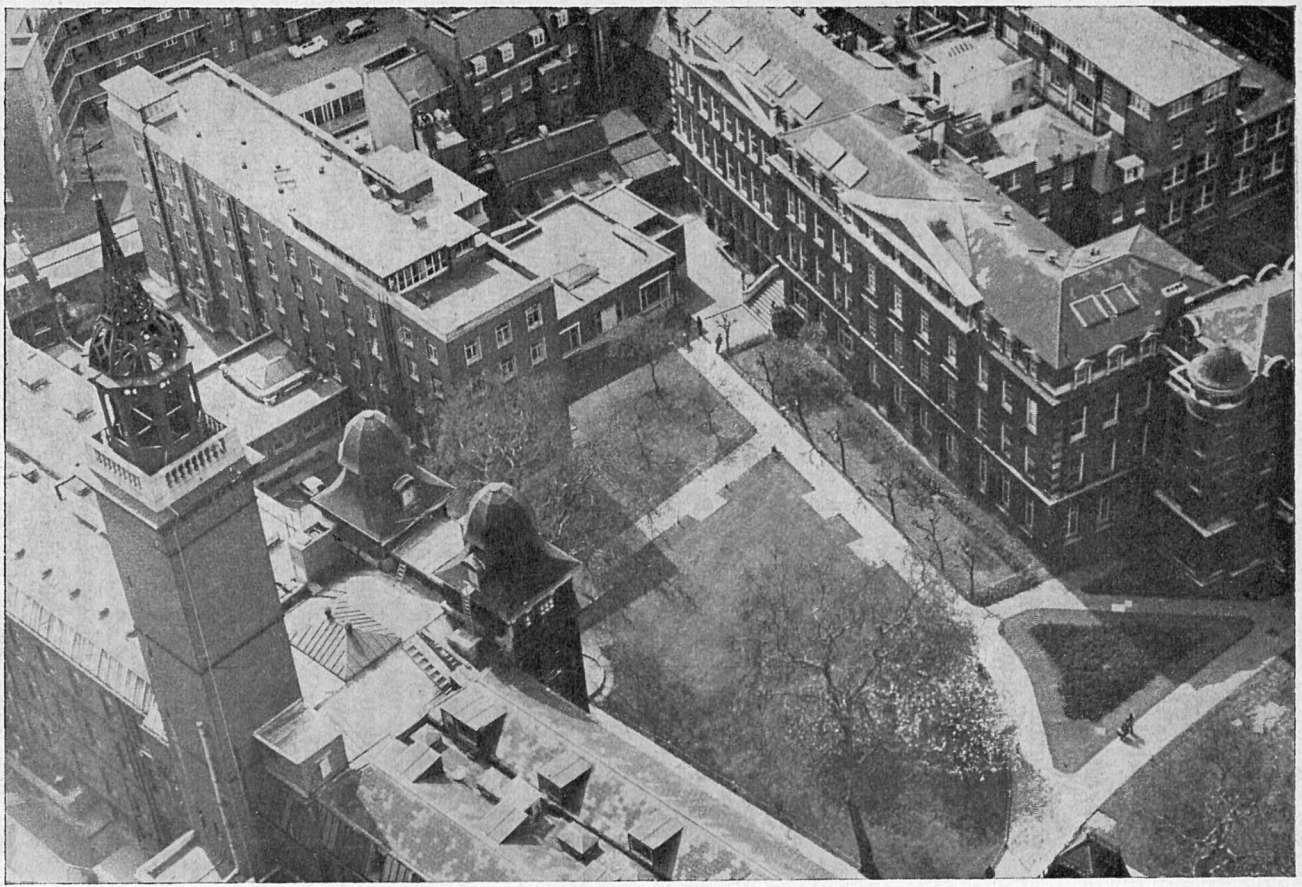
A series of dinners, for the benefit of War on Want, is to be held at Guy's in the near future. Further publicity will precede them.

GUY'S DIARY

JULY

19 M 1.00 Clinical Lecture. Dr. HOSKINS.
"Radiodiagnostic Aspects of the Breast."

23 F 1.00 Clinical Lecture. Mr. O'FLYNN.
"Diverticular Disease of the Colon."



The park, Hunt's House, Nuffield House and the Medical School as seen from the tower.

High on the south side of the tower.

The Music of Brückner

G. L. Davies

"Then felt I like some watcher of the skies
When a new planet swims into his ken."

Not to have had even a nodding acquaintance with Brückner until about three years ago is, perhaps, a mildly shocking confession by anyone professing to be a lover of classical music. We excuse ourselves of course by saying that we cannot always be listening to music. Life is too short and there are many other things to do. There is always a tendency, too, to hark back to old favourites instead of embarking on something new. Besides even good music can pall . . . "Give me excess of it that, surfeiting, the appetite may sicken and so die", as the Duke says in the play. But Brückner has now come to stay, after his long near-oblivion, as a popular item in a concert programme. To equate my own feelings on first hearing a symphony of Brückner's with those of Keats "on first looking into Chapman's Homer" is no doubt to make a highly unjustifiable assumption. First impressions, however, whatever the mental status of the person concerned, and whether they be of sight or of sound, have some indefinable spiritual quality depending upon the sensitivity of the viewer or listener, and usually can never be recaptured. In the case of Keats, it led to the writing of his sonnet which he dubbed "On first looking into Chapman's Homer", and the reading of which gave me my first introduction to Keats when I was a boy. Did Cortes ever again (though the story is mythical) gaze upon the Pacific as he did on the occasion when he was "silent upon a peak in Darien"?: or, much later than that, did Delius *every* Spring burst into a lyrical, musical rhapsody on first hearing the cuckoo?

Brückner was the son of a poor schoolmaster in Austria, a member of the Catholic peasantry, in fact, "the most primitive stratum of European society", as one writer says. By virtue of his musical gifts alone, he raised himself from his humble status and became well-known as a teacher and organist. In 1856 he was appointed organist to Linz Cathedral, by which time he had written much music, mostly liturgical. It was now that he became more acquainted with the music of Beethoven, and, more important still in his case, with the music of Wagner, who did so much to bring out his latent genius. "Wagnerian romanticism was grafted on to the pure harmonic and contrapuntal style which he had adopted, and which stemmed from the 16th century". It was under these influences that he composed his first masterpieces, the Masses in D minor, E minor and F minor, at a time when he was already over 40 years of age. At this epoch, too, he composed his first mature Symphony, the No. 1 in C minor. Having now gained a professorship in the Vienna Conservatoire, he became almost exclusively a symphonist. His career as such, however, was not destined to be a smooth one. To express his own personal vision, he had to create a new type of Symphony, "vast, stark and rough-

hewn", and, for that reason, it is of no use trying to evaluate Brückner by criteria applicable to Beethoven and Brahms.

He was a man of strong character, and of deep religious faith, and he did not allow himself to be affected by the fashionable habits whether of mind or of dress of the Austrian capital. In composing his nine symphonies, he was, nevertheless, "a highly skilled craftsman, erecting to the glory of God huge cathedrals in sound".

The novelty of his works stirred up much hostility, and adverse criticism was made of the reputed Wagnerian influences in his music. He denied their existence and, in fact, his music was quite un-Wagnerian in spirit. Disparaging remarks, too, by Brahms did much to impair the success of his symphonies in Vienna. Mahler, however, befriended him and even conducted one of his symphonies; but it was not until his 60th year that the performance of his 7th Symphony proclaimed his musical genius in Austria, Germany and Holland, but not in the rest of Europe, except for an increasing number of admirers in Great Britain. One of the reasons for the failure of universal admiration of Brückner symphonies has been what has been called "the Brückner problem", and this again has been due to the various versions which exist of most of his symphonies. Mangled versions of Brückner appeared in the first editions of his symphonies published between 1878 and 1903. Conductors, too, made confusion worse confounded, not only by using the discredited early versions, but they made cuts of their own and played fast and loose with the tempi. For instance, they often practised a very slow tempo which takes away all vitality from the music. It has been said of Brückner that, though he wrote nine symphonies, he really only wrote one because of a certain repetitive element occurring in all of them. One needs to be an expert no doubt to detect this.

In listening to Brückner's symphonies, one notes the long pause between movements, and it is said that his music "emerges from silence", an easily observable fact. The next movement will start quietly for a few bars, to be followed at times by a tremendous crescendo of sound. Much of this may be of the "vast, stark and rough-hewn" character referred to above, but interspersed now and again with music of a glorious melodic type. His opening movements are usually followed by the slow movement and then the scherzo with its characteristic "blaze up" of sound. "The undeniable sublimity of Brückner's slow movements has made them the most widely admired aspect of his art, and the greatest are undoubtedly those of the last three symphonies". There is a certain liturgical character about some of his music, suggesting as it does Roman Catholic hymnody. In discussing the definition of the expression "regular concert-goer", the music critic Martin Cooper, in his column in the *Daily Telegraph* of 24.4.71, contended that a Brückner audience contained more regular concert-goers than a Brahms audience (as I took it to mean), and that 90 per cent of these attended concerts for their programmes and not to hear a particular conductor or soloist. In view of the great musicality of Brahms, this seems surprising. What is surprising, too, is the mutual dislike of Brahms and Brückner for each other. They

were, it is true, close contemporaries, Brückner dying a year before Brahms at the age of 72, and Brahms at the age of 64. Brückner, like Mozart, had a difficulty in establishing himself, and perhaps felt somewhat embittered by the easier success of Brahms, for he himself was still struggling to complete his No. 9 Symphony even on the day of his death.

NOTICES

THE THEATRE CLUB

Anyone interested in producing or directing the Theatre Club's Christmas production is invited to contact the Hon. Secretary in the East Wing. No previous experience is required and any play or ideas will be considered.

DO YOU SINCERELY WANT TO BE RICH ?

Two clinical medical students are required by Educational Television Service to help make a series of educational programmes on Medicine. It will involve two days a week for seven weeks during September and October.

Would anyone who is photogenic and interested contact R. M. Darling via the East Wing as soon as possible.

The Management of Rheumatoid Arthritis

J. C. Robertson

The management of a disease depends on its cultural, economic and political contexts. A doctor may be responsible to a government or city for the management of an epidemic, or be asked to advise on treatment, prevention, or priorities regarding allocation of scarce medical resources. Or he may be concerned with an individual, when management is affected by the patient's age, psyche, job, social status and his particular pathology, as well as the medical resources available. The use of these resources is influenced by the current practice of medicine, which depends on the contexts mentioned.

In socialist countries taxation must be heavy to support the Welfare State. Heavy taxation weakens the individual's power to look after himself and places a correspondingly heavy responsibility on the State to look to the completeness of its services so that no unusual, or unthought of, human needs are unprovided for. Similarly, if a State nationalises medicine the individual doctor's income falls and he has less economic power of his own to use as he wishes in his practice among patients. He becomes more dependent on the State to provide the means for treatment, rehabilitation, and research. The State may misuse this power as a review of the East German Medical Service shows (Cammerling 1970). The concept of a profession has arisen from the realisation that some arts are not easily understood by laymen. The layman, or client, chooses to trust the judgment a professional body exercises when it bestows membership on a practitioner. Professional bodies have become more important since the nationalisation of medicine, for they are the most independent and informed critics of the service.

While medicine is international, the British patient and his Health Service are at any rate national, until we join the Common Market. In days when the quality of the practitioner was the chief parameter affecting medical care, the medical profession's preoccupation was to maintain his standards of practice. Now the professional associations have the additional duty of ensuring that the State actually provides sufficient resources for medical care. Without adequate resources a doctor cannot exercise his right to full clinical freedom, that is, freedom to practise first-class medical care. The B.M.A. has not only to advise the Ministry but to press Parliament for a higher priority for medicine.

The difficulties that the British doctor faces in the management of his rheumatoid patient illustrate the failures of modern medical care, its complexity and dependence on resources, and are exemplified in the following case histories.

1. A young West Indian nurse developed acute generalised

rheumatoid arthritis of severity sufficient to warrant admission. She had a two-month-old infant whom she breast fed. Her husband could not give up his work and no home helps were available, so rest at home was not possible. If she had been admitted to a general medical ward there would be no provision to continue looking after the baby. It was not possible to arrange for her to stay on the paediatric or maternity wards.

2. A fifteen-year-old boy developed Still's disease. His teacher could not provide him with work on the general medical ward, and the specialist unit with educational facilities was far away and full. There were no regional facilities for the young chronic sick, so he remained in the acute general bed.

3. An obese widow of 60 was unable to manage at home despite home helps who visited twice weekly, meals on wheels and a tired district nurse. Her daughter was unable to look after her. She was admitted ostensibly for reassessment and further treatment, as there were no day-centre, hostel or sheltered accommodation facilities. Her rheumatoid arthritis was not very active but her osteo-arthritis was severe. Despite elective orthopaedic surgery she was unfit to return home. After three months in an acute bed she was transferred to a chronic geriatric unit where she remained.

4. The general practitioner of a busy housewife with four children failed to obtain a home help for her. Her generalised arthritis persisted and she was unable to rest sufficiently. Depression and a symptomatic detrioration occurred. After an overdose, she "rested" in hospital while her husband was forced to take time off from work.

5. A young family man developed acute rheumatoid arthritis. He improved and was discharged after five weeks. His home was damp and overcrowded and on the third floor of a tenement. The housing committee could not help. Further improvement was slow and he was not fit to return to his job as a coalman. A lighter job was not found. He relapsed and synovectomy was performed with good effect, but the industrial resettlement officer still could not place him. Later on, complications of his persistent arthritis and of the therapy developed, involving him with a bewilderingly large team of social and medical agencies (he was still out of work). Many of the staff were training and there was a high "turnover" amongst them.

As many as fourteen professional workers have been concerned in one case and seven of them were social workers (Garrard, 1970). Factors influencing the numbers of staff a patient sees include movement of patient or staff to different areas, provision of locums, promotion and specialisation.

The workers involved at this stage of his disease may have included his general practitioner, the three other partners in the group, and their locums, receptionists, and the health visitor or nurse. The local authority may have provided aids, and the social security may have advised him about benefits, as may the hospital social worker.

The ambulance service ferried him to the out-patients' clinics and physiotherapy department where different receptionists and professional staff saw him. He has visited the pathology and radiology departments.

Complications such as carpal tunnel syndrome resulted in referral back to the orthopaedic department for splinting and injections. Relapse occurred and he was re-admitted, meeting a new ward sister, house physicians and physiotherapist. Depression occurred, but was not severe enough to warrant a psychiatric opinion. With rest, he improved and was sent home. He attended medical out-patients regularly, and was followed at the eye clinic as he was on chloroquine. Wax baths, twice weekly, continued for some weeks. He was fit enough to visit his chemist and the Ministry of Social Security, while his doctor called on him once or twice a month. A rash occurred and persisted so his chloroquine was stopped and steroids were started. A year later he suffered a haematemesis and was taken into another hospital. Fortunately, bleeding stopped after the surgeons saw him. The radiologist confirmed no abnormality in the barium meal.

Another rash developed and resisted treatments so he was referred to a dermatologist. At the clinic his urine was tested. The monilial rash cleared and his diabetes responded to the diabetician's régime. Meanwhile, the general practitioner had treated the patient's wife for depression and was relieved that the eldest child's behavioural problems were responding to simple psychotherapy. It was fortunate that the wife avoided another pregnancy and that the family had good neighbours who helped with the younger children.

The last case explains the popularity of General Practitioner-run Cottage Hospitals, where staff "turnover" is low and visiting is easy, and the "Specialist" visits occasionally. However, such a unit may lack support services and may not be able to treat the more acute complications. The proposed scheme is for a physician "with an interest" to manage the rheumatoid patients in the catchment area of the district general hospital. Such a physician would have to look after the 2,000 or more severe rheumatoid arthritics which the 200,000—300,000 population served by the hospital would produce (Editorial 1969, *Brit. J. Hosp. Med.*)

If the problems of continuity of care were to be solved he would require the backing of a unit with its secretary, social worker, occupational therapist, and ward staff. An assistant might provide continuity of care in out-patients. The physician should have facilities for clinical research, and for close orthopaedic liaison. The latter might be achieved by running a combined clinic.

An overseas doctor surveying British medicine would soon realise that rheumatoid arthritis was an endemic disease of epidemic proportion, affecting 2.5% of males and 6% of females over the age of 15. The prevalence rises with age so that for men between 54 and 64 it is

5% and for women 15% (Lawrence 1964). Other studies suggest that up to 11%of men and 27% of women had suffered some clinical grade of rheumatoid arthritis.

He would read in a recent journal (Nukir G. and Whaley K., 1969), that there is "no clear guidance as to whether therapy of any kind aimed at inducing a remission of the disease or reducing the severity and extent of the tissue inflammation has any intrinsic value". He would be disappointed to find that with conservative treatment, including bed rest in hospital, salicylates and splinting, only 20% of 307 patients were fit for all normal activities seven years after discharge. Until research has revealed the cause, prevention and improved treatments will be impossible.

The aims of management are prevention, early detection and treatment with avoidance of complication and disability from the illness or its therapy, and as complete rehabilitation as possible. By the latter is meant return to family and work, or achievement of as independent a state as possible. Management should also aim to reduce the ill-effects of disease on the patient's family.

While these aims may be implicit, they are not stated in the latest Green Paper on the National Health Service (1970). Mr. Crossman believed that there were four basic principles on which the service should function, and he felt that they had stood the test of time. They are :—

(1) That finance should be raised from the well and not from the sick ;

(2) The service should be of the same high standard in all parts of the country and in every branch, whether geriatric, subnormal or chronic sick ;

(3) That the service should provide full clinical freedom; and

(4) That it should be centred on the family doctor team to provide the essential continuity of care for the individual.

Where research has not revealed the aetiology of a disease, prevention is not possible. Significantly, neither prevention nor research were included in the basic principles, yet tomorrow's management is based on today's research. The increased prescription charges negate the first principle, the vagaries of regional finance the second, lack of resources prevent a physician exercising "full clinical freedom", and under the present arrangements even the most ardent G.P. cannot ensure "continuity of care".

Review of the management of rheumatoid arthritis points to the need for adequate financing of the health service. While the present service may appear to satisfy the public it does not meet with the approval of the staff who work in it. Medical emigration and immigration are symptomatic of this, as is the high fall-out of nurses from training and the shortages of staff in general. While the National Health Service is efficient if judged in terms of value for money spent, it could be more efficient if it were not so under capitalised. Either

medicine takes a higher priority in the budget, or the National Health Service continues to run risks, or it charges for items of service, or a major reduction in running costs makes it more efficient. Taxation will not countenance a budgetary increase and the charges for item of service schemes may increase hospital bills by up to 30% (i.e. the cost of accounting.) Item of service schemes are proving too expensive in America.

A major reduction in running costs seems to be the only way to provide more money for the Services. Charity is unlikely to be a sufficient alternative source of finance. However, the Service employs three quarters of a million people and their wages account for some 70% of the running costs. If conscription was justifiable to maintain the defence forces when the nation was too poor to pay attractive enough wages for servicemen, then it is certainly reasonable to suggest that such a method be used to maintain the National Health Service. Conscription into the National Health Service and Welfare Services might be more beneficial to the conscripts than military training. One of the advantages of such a scheme is that it could educate future citizens about the complexities of the State Services and the magnitude of their difficulties. The Welfare State might be less taken for granted and used more wisely by the public.

Some might feel that Health Services were not worthy of greater priority but they should realise that $1\frac{1}{4}$ times as much is spent on defence and two-thirds as much on smoking. They should also reflect on the fact that we spend a smaller proportion of our gross national product on health than other countries. In the year 1961-62, we would have spent £250 million more on health if we had paid the same percentage of our gross national product than countries with a similar per capital national income, such as Australia pay. £250 million amounted to a quarter of the expenditure for that year. While other countries spend about 1% more of their gross national product on health every ten years, our rate of increase is 0.4% in six years, so there is no reason to suppose that the National Health Service's financial status has improved since 1962. (Maxwell 1969).

Summary

While the aetiology and treatment of rheumatoid arthritis remain controversial, prevention will be impossible and management will be preoccupied with ameliorating the physical, psychological and social disabilities that the disease and some of its therapies cause. Case histories illustrate the difficulties in management and demonstrate the dependence of the latter on adequate resources. The failure of the National Health Service to provide such resources is discussed and found to be related more to the low priority given to the Health Service by the State, than to the actual structure of the Service. The rôle of the health professions' associations must extend to include a

political interest in the way the government treats the National Health Service.

If the service given by an individual practitioner falls short of the required standards, the profession may act to prevent recurrence. What if the service given by the State is inadequate by the same professional standards? The medical profession has advised the State long enough about the National Health Service. Perhaps it has a duty to oblige the government to provide for the first-class service that the staff of the National Health Service would wish to give the public.

References

CAMMERLING, R.—Pulse, 17th and 24th October (1970).

EDITORIAL.—*Brit. J. Hosp. Med.*, **2**, p. 1915 (1969).

GARRARD, J.—Resources in Hospital Medicine (King Edward's Hospital Fund for London), p. 42 (1970).

LAWRENCE, J. S.—Textbook of the Rheumatoid Diseases, 3rd ed., p. 93 (1964), (F. S. S. Livingstone Ltd.).

MAXWELL, R.—*Brit. J. Hosp. Med.*, **2**, pp. 895-6 (1969), quoting from Abel-Smith, B. (an International Study of Health Expenditure and its relevance for Health Planning, Public Health Papers No. 32, W.H.O.

NUKIR, G. and WHALEY, K.—*Brit. J. Hosp. Med.*, **2**, p. 1958 (1969).

BOOK REVIEWS

FIVE QUESTIONS IN SEARCH OF AN ANSWER.

David Stafford Clark. Thomas Nelson and Sons, Ltd., 1970. Price £2.25.

The World's Churches have recently faced considerable criticism, particularly from radicals eager for social change and unwilling to be delayed by the promise of a better existence in the next life. Inevitably, some of this criticism came from doctors struggling with the problems and casualties of disease, famine and disaster. Psychiatry has raised its own issues such as the effect on an individual's spiritual development of a psychotic or dementing process.

In this little book, Dr. Stafford-Clark has selected for discussion five more elegantly phrased questions, drawing on his wide personal experience and literary knowledge. In presenting them, he reveals something of his own struggle to find solutions, and manages, perhaps surprisingly in a "first essay in sincere heresy" to end on a hopeful note. Stylish and appealing, this book will provide plenty of material for discussion by those interested in the relationship between human beings, their environment, and their Gods.

K.F.S.

PRINCIPLES FOR FIRST AID FOR THE INJURED.

H. Proctor and P. S. London. 2nd Edition. Butterworth and Co. £2.

The second edition of this most valuable book will be welcomed by all those who are responsible for the teaching of First Aid. A revolution has taken place in the application of some long established procedures for the immediate aid to the injured, in the hands of average lay people, either entirely unskilled, partly skilled, or the well-trained First Aid personnel. This book goes deeply into the reasons why some types of aid are valuable and essential, and some "aid" can do more harm than good.

As always, the best aid is to get the patient as quickly as possible into the hands of a medical man and the Casualty Department of a hospital.

E.P.M.

NURSING SECTION

The Salmon Reverses

It seems that at last, somewhat belatedly, the Nursing Profession has realised the errors of the Salmon System. The leaders have now accepted what the workers told them at the time of publication of the Report. Namely, that there would be no experienced ward sisters left to supervise the wards, and that the grade of number seven would not solve the difficulties thereby created. Unfortunately, these people chose to ignore the forebodings and are now trying to cover their mistake of jumping headlong into a system to which they had given insufficient consideration. They are now having to change their horses in mid-stream, and thus the term Clinical Consultant is to be frequently heard bandied around the committee rooms. Having pushed the Senior Ward Sisters unwillingly into posts which they neither desired, nor for which they were trained, the hospitals have realised that the stability in the wards has totally collapsed, that the standards of care have fallen, and that it is impossible for one person to give adequate help and guidance in four wards simultaneously.

So, now it seems everyone is to be encouraged to progress in the clinical field, and leave administrating to people who were trained in that, and who might possibly prove competent to undertake it.

It is a source of great irritation to many, that these ideas were not instigated earlier. Many people have had their careers ruined as a result of the event of recent years, not to mention their happiness. This latter is an aspect which nowadays is frequently ignored. However, since people usually show better performance when they enjoy their work, it is surely foolhardy to overlook the fact. It seems, however, that this is unfashionable nowadays. In addition, nurses being as they are, usually most reluctant to admit having made a mistake, would never concede to this idea.

If, then, there is to be encouragement to continue clinical work, would it not be sensible to construct a proper career structure. The young ward sister at the time of her appointment should be fully versed in the opportunities ahead. At present she is at a loss by the time she is about 26—30 years of age. She has the scintillating choice of administration, teaching, or stagnation. She frequently rejects all these and changes her job. Therefore, many able people are lost annually quite unnecessarily. There is usually nobody with whom she can discuss the future constructively. If the somewhat limited opportunities are declined it is taken to be a personal insult to the authorities. Once established as a ward sister, the only way to improve one's education is to undertake a Sister Tutor's course, this does at least bring another qualification. However, not everyone wishes to do this, and the only other outlet is a management course. This will carry no qualification, just a somewhat dubious piece of paper stating that one's attendance has been observed.

If, then, the organisers of the nursing service in this country wish to retain their experienced employees and ensure the standard of care to which the patients are accustomed, they must surely establish a suitable career structure, acceptable to the type of person whom one would like to think will be wishing to undertake nursing. These people, however, will not come forward until they are offered a career rather than just a three-year training.

SURGICAL COURSE SHOCK DEMAND LEAK ROW PROBE LOOMS

"Ward Clerk's" letter, following so soon on the remarks of "Leucocyte", will, it is to be hoped, have the effect of drawing the attention of the authorities to the great need there is at present for a systematic course of instruction in antiseptic and, more especially, aseptic surgery. At the present time, few men have the opportunities of even grasping the elements of this improved mode of treatment, and we cannot help thinking that the institution of such a course would be justified by the attendance of many who are no longer ward clerks, yet equal to them in ignorance in aseptic matters, and from whom example is taken and habits acquired.

(From the *Gazette*, 18th July, 1896)

CORRESPONDENCE

Academic Successes

SIR,—Stirred, as most Guy's-trained pathologists will have been, by depressing correspondence on the low standards and pass rate achieved by final year students taking pathology, I write to inform readers who are concerned to see Guy's keep its traditions in this field that the pass rate in the difficult final examination of the Royal College of Pathologists was 100 per cent at the last examination:—

Alan Stevens of the Department of Pathology, and Graeme Roberts of New Zealand, together with Farouk Presswalla of Bombay University, both in post-graduate training in the Department of Forensic Medicine, being successful on their first appearance.

This is no mean achievement, for the M.R.C.Path. is entirely comparable with the M.R.C.P. and the F.R.C.S.Eng., as a real test of specialist knowledge.

I am, etc.,

KEITH SIMPSON.

Department of Forensic Medicine,
Guy's Hospital, S.E.1.

SIR,—I have only just read your paragraph in the issue of 19th June congratulating several Guy's graduates on their recent academic successes. May I please add my congratulations to yours.

However, from the list of those who have just attained their final F.R.C.S. at the first attempt, you omit David Mathias and Roger Parker, both Registrars in the Throat and Ear Department.

Yours, etc.,

L. F. W. SALMON.

Guy's Hospital,
London, S.E.1.

Security Guards

SIR,—We deal with public relations matters for Securicor, and our attention has been drawn to the issue of your journal No. 2162 and the article on page 277. We are very sorry to learn that the Securicor guards going about their work at the hospital have caused you some concern. I appreciate that the incident to which you refer was on 21st May, but a campaign of this type in a very large company does take time to gather momentum to produce results.

Securicor does not approve of "irresponsible and arrogant type of behaviour", and the management of the company objects to it as much as you do. Every effort is made to prevent this type of attitude.

However, on the general subject of cash-carrying, I must tell you that it is a very hazardous job in these days of violent crime, and one of our men has been killed and several injured whilst on duty. Deliveries to hospitals are particularly vulnerable, as bandits can put on white coats and overalls and mingle with the doctors, students and staff who have a right to be on the premises. It is an unfortunate fact that many security guards, including some of our own, have been brutally attacked whilst on hospital premises.

Your report has been brought to the attention of the department concerned, and whilst we do not agree with all the points which you make, every effort is being made to improve the overall impression to which you have objected.

Yours truly,

ERNEST JOYCE.
Public Relations Officer, Securicor.

Grand Buildings,
Trafalgar Square,
London, WC2N 5HB.

Pupil Nurse Training

SIR,—I am sure it will be of interest to your readers to know that the Guy's Pupil Nurse Training School, formerly based at New Cross Hospital, will shortly be moving into its new accommodation in the main School of Nursing.

We are very anxious to attract young men and women to Pupil Nurse Training. We should prefer candidates to have at least two subjects in either C.S.E. or G.C.E. subjects, but should be willing in certain circumstances to administer an Entrance Test to those with no educational qualifications.

We do hope that those who read the *Gazette* will help us by making the Guy's Enrolled School known to the young men and women of their acquaintance.

BRYSSON WHYTE,
Principal Nurse Tutor.

School of Nursing,
Guy's Hospital,
London, S.E.1.

SIR,—In support of N. J. Knott's letter of 19th June, 1971, I, too, have been progressively irritated by the reports in the sports columns of the activities of the cricket club this year.

In the early sixties, Guy's was proud of its cricket club; it was unquestionably the most successful of all the hospital sports clubs at the time, it boasted many fine players, some of whom had played for their counties; and those of us who were officers of the club during this period, worked hard to promote its prestige on and off the field among the senior cricket clubs of the Home Counties.

Your correspondents now appear to be proud of the fact that they can report only being able to muster ten players for a club fixture that we worked hard to establish, and positively elated if they can blame their inevitable downfall on the previous night's inebriation. If this is the best they can do, then let us hear no more of the cricket club in the *Gazette*—ridicule and mockery are best left unpublicised.

Yours faithfully,

IAN REEKIE.

Manor Cottage,
Moreton-in-Marsh,
Gloucestershire.

SIR,—I find it most disconcerting that my valuable time is wasted playing the game of outsmarting the lifts in New Guy's House. The relatively simple act of getting in or out of this majestic edifice has become a neo-Classic Machiavellian nightmare. The process starts by pushing the call-button; a light might sometimes acknowledge the request. After several long and frustrating minutes, a lift arrives with a clash of bells or else so silently that its presence can be missed.

Once inside the lift (assuming that it is going the right way), it is several minutes before the journey is complete. This gives one time for thoughts like "Why do these lifts always stop at the first floor?" or "Who put up that NO SMOKING sign?" Only yesterday the lift I was in seemed to be taking a rather long time to get from the fourth to the third floors. Since nothing happened for about twenty miutes. I tried pressing the alarm bell and just about every button I could find. At that point the machinery made a spontaneous recovery, and five minutes later I escaped from the lift at the ground floor.

I find it quite remarkable that four lifts serve eleven floors with such inefficiency. If a trip to Esther ward is an afternoon's work, a visit to the lecture theatre in the Tower Block might well be a day's excursion. It is a sad situation when the lifts in a bourgeois building such as the Hilton are better than those in New Guy's House, which is the pride of the N.H.S.

Assuming that I am not trapped again, I beg to remain your humble and obedient comrade.

Yours ever,

ARNOLD SCHULTZBERGER.

East Wing,
Guy's Hospital.

SPORT

BLUES

The following awards have been made:—

Athletic Club

Full Blues	Half Blues
K. Sheppard	L. Ross
J. Shutes	W. Konarzewski

Boat Club

N. Bax	G. Moulding
A. Batch	R. Pinkney
	P. Stevenson-Moore

Boxing Club

T. Reynolds

Hockey Club

R. Fell	P. Calvert
	B. Martindale

Rugby Football Club

A. Fallowfield	C. Croft
R. Burt	G. Evans
D. Stuart	M. Danford
R. Barough	T Higenbottam.

Squash Club

E. Evans
J. Mackay

ROBERT GOODHART
Hon. Secretary, Blues Committee.

ATHLETIC CLUB

MATCH v. MIDDLESEX HOSPITAL AND ST. MARY'S HOSPITAL

23rd June, 1971. Result: Guy's 73, Middlesex 74, St. Mary's 50.

In this very close match, Guy's lost sadly because of three missed throws by K. Sheppard in the discus, although far outdistancing his opponents. This match was, however, a very satisfying one for our athletes, especially R. Nicholls, who at long last equalled his previous best time in the 200m. with a time of 22.4 secs., a very creditable performance. This was not long after a 100m. in 11.6 secs., a seasonal although not a personal best for him. Kevin Brame showed that he is not just a long jumper, but can run as well with a 200m. time of 23.9 secs. Guy's have a good sprinting tradition and this should be maintained by these two in future years.

Other good performances were by K. Sheppard in the shot with 33ft. 9ins., and B. Jones in the 800m. with 2m. 6 secs., both seasonal bests. N. Bloom came second in the 400m. with a relatively slow time of 55.4 secs., but with training, he is undoubtedly capable of greater things. M. Avery tried yet another event, this time the discus, gaining some valuable points, and also helped the scratch relay team to victory in 46.6 secs.

Team: R. Nicholl, M. Avery, N. Bloom, K. Brame, K. Sheppard, B. Jones (captain).

B.J.M.J.

UNITED HOSPITALS SPORTS

Motspur Park. 15th May. Result—Won.

Guy's once again carried the field, this time defeating close contenders, St. Mary's, by 20 points. We have not released the U.H. Shield from its space in the Medical School Office, since 1963, and hope to win it ten times before it is taken from us. With the new athletes making their mark, this objective seems quite possible. However, performances were on the whole worse than at the U.L. sports despite better conditions. Kevin Sheppard failed to beat P. Holliwood of the London Hospital in the javelin, having won by five inches two weeks before. Bill Konorzewski proved an invaluable member of the field events team, scoring many points once again. Paul Bond is still lacking something in his high jump style, but won with 5ft. 9ins., gaining a cup.

M. Avery won the 110m. hurdles cup with P. Bond a close second, his first 110m. hurdles. Micks' times have only recently improved after a long period with poor times, rather like Roger Nicholls, who is still too tense before races.

We were very pleased to welcome two old members, I. Morgan and Friday Nwator. Between them they scored a number of points: Ian being 1st in the 400m. hurdles, Friday in the 100m., and a combined effort in the relay.

E. Gavin came 3rd in the 800m. with B. Jones a close 4th, although neither were at their best. Mick Bloom narrowed the gap on M. Wink in the 400m., coming 4th and 3rd respectively, Mike recording a personal best of 55.1 in a heat. Les Ross scored 5th place in the 2000m. steeplechase, a good reward for his usually unfruitful efforts.

J. Shutes and Kevin Brame have yet to decide which of them is the better in the triple and long jumps, both of them improving their jumps.

After the competition, it was generally agreed that at last someone had tried to beat us, and thereby made the competition so much more enjoyable.

B.J.M.J.

UNIVERSITY ATHLETICS

So far this season, Guy's has supplied the University with seven athletes. Some have been more successful than others, but all have improved their performances after a strange period when clearly they were not at their best. Best performances have been :—R. Nicholl (11.7) 100m.; M. Avery (17.9), 110m. hurdles; E. Gavin (2.43), 800m.; B. Jones (61.5), 400m. hurdles; J. Shutes (19ft.), long jump; P. Bond (5ft. 9½ins.), high jump; K. Sheppard (205ft. 10ins.), javelin.

M. Avery, Paul Bond and Kevin Sheppard represented U.L.U. at the British Universities Championship (B.U.S.F.). Mick was knocked out in the heats of the 110m. hurdles, and Paul came 7th with a below par jump.

However, Kevin Sheppard came second in the javelin with a throw of 190ft., 33ft. below his all-time best and with a poor borrowed javelin. Perhaps the most important result of the whole season was Kevin's performance in the Surrey A.A.A. championships, when he won the javelin with a throw of 215ft., again 8ft. below his personal best.

There was a time when Guy's could boast a whole team of Kevin's standard, but in these hard times for college sport, we should count ourselves lucky to have anyone at all.

B. JONES.

CRICKET

Guy's v. Mayfair C.C. Sunday, 27th June. Guy's won by 79 runs.

Guy's won the toss on a gloomy day at H.O.P. and elected to bat. This proved to be a good move because Guy's recorded their highest opening partnership of the season with 127.

Langdon scored 73 and played very well, his off-driving especially, a joy to watch. Gillham supported well, scoring 46, before being adjudged lbw.

Guy's were thus able to declare at 155 for 4, leaving themselves plenty of time to bowl out the ten members of the opposition.

They achieved this without undue trouble, Henriques taking 4 for 30, and Harris 4 for 27. Gillham picked up the other wicket.

The fielding on the whole was good, Clifford-Jones especially, holding two fine catches and stopping many runs in the covers.

Team: Langdon, Gillham, Clifford-Jones, Hemmings, Henriques, Harris, Das, Young, Underhill, Cheguiddens.

MATCH v. M.S.S.

H.O.P. 2nd June. Won.

By amazing good fortune, Guy's took the field with 11 men, while the opposition could muster only nine. Having been inserted by the opposition, Guy's got off to a good start with Langdon taking nine off the first over, but in the second a complicated mix-up resulted in the run-out of Oram. Langdon played back by mistake and was bowled, having made a good, quick 29. Fitton batted steadily while wickets fell, but a good stand between Fitton and Brophy ensured a reasonable total. Fitton ended with a good safe 51, which included some good lofted drives. Brophy made 25, and Guy's were all out for 132.

Ramsay had no luck with the ball, but Davies and Harris took four wickets apiece and M.S.S. were all out for 105.

MATCH v. PAST

H.O.P. 5th June. Drawn.

Ian Munro won the toss and decided to bat, but regretted this decision almost immediately as he was caught behind off Harris, first ball of the match. John Williams went quickly, but David Silk (batting as gracefully as ever) and Peter Swift managed to get stuck in. Silk made a good 33 and was out just before lunch, and Swift, who had been dropped twice, was not out at 28.

After lunch, Davoodbhoy batted forcefully and made 28, and Swift went on to make a very good 80. Evans made two good stumpings, and Mike Fordham made more runs in one innings (9) than I think he has in his previous five years for Guy's, which enabled his captain to declare at 214 for 9. Gillham bowled well to take 4 for 64 (swinging the ball both ways), and Goodhart took 4 for 76.

Langdon showed himself to be in an obstreperous mood as he viciously square cut the second ball he received from Henriques for 4. Gillham and Langdon had a good opening stand for 47, which included five threes and one run four, which is probably the reason why Gillham was out just before tea. The best over was the one from Beecham, when Gillham hit 3 off the first ball, and Langdon hit 4, 4, 2, 4 off the next four deliveries. However, Beecham got his own back with the last ball, which hit Langdon just where it hurts.

Burns was out quickly, but Langdon and Evans had a good stand of nearly 90, which was mainly due to some very good running of singles which had the fielders working hard. Evans was out for 30, which included, uncharacteristically, only one four, and with Goodhart joining Langdon at about 75, it looked as if we could coast home. However, Langdon seemed to close up, and was soon caught behind (it is fatal to cut Davoodbhoy) for a good, chanceless 83. With Rees, Brophy and Hayes all falling quickly, Guy's played out time and ended up with 185 for 8.

MATCH v. HAMPSTEAD

Away. 6th June. Lost.

The pitch was like concrete, and it was not surprising that Hampstead elected to bat. They eventually declared at 2.40 p.m. with 248 for 5—two of their players making 75. The Guy's fielding was generally poor and lethargic, and one or two easy catches were put down.

Langdon received a perfect ball, and Gillham, Goodhart and Evans were all caught behind the level of the wicket in their teens. Clifford-Jones made a very reasonable 22, but no one else made a significant total, and we were all out for 111. We only had 10 men as Alban Davies was unfortunately taken ill at Shrewsbury.

INTER-HOSPITALS CRICKET CUP

2nd ROUND v. ST. MARY'S

7th June. Result: Lost.

This is, possibly, the best game of cricket I have ever played in. Mary's put us in as the pitch was damp and patchy. The pitch was playing up and Langdon was out when a ball stopped. Holland batted like the stalwart he is, but was hit all over the body, including two consecutive very painful blows on the fingers, which were badly injured, although he managed to bat on. Goodhart and Evans were out cheaply, but Clifford-Jones got his head down and stayed until lunch. Holland was out just before lunch just as Fitton arrived from a wet weekend (address uncertain!). At lunch, then, the score was 75 for 5, and we were pretty much down. After lunch, Clifford-Jones hit out and scored a good 39, and Danford and Fitton piled on the runs. Fitton went on to make his usual 50, and was eventually run out. Danford showed us some wonderfully exciting shots and was removed only after he had scored 42. So from Mary's being well on top, Guy's had the upper hand and were able to declare at 230 for 9.

P. Goodwin, Mary's main batsman, was dropped early on, which could have been a bad mistake, but when he eventually went and Mary's were 97 for 5, it looked as if we could run through them. The fielding was generally good, although there were one or two possible catches downed. Bulow came in at 7 and began to stay. He got away with it until he was 40, when an easy catch was dropped at cover, which probably lost us the match. They needed 100 to win in the last hour, and when Bulow was eventually out for 91 (3 sixes), they needed 30 to win in 15 minutes with two wickets left. The Mary's captain told them to play for a draw, but they didn't, and they got home with one minute of an 11.00—8.00 game left. A great pity for Guy's, but a great game of cricket.

Score-card: Guy's—C. Langdon, c, 8; A. Holland, b, 45; R. Goodhart, c. 9; G. Evans, c, 2; R. Fitton (run out), 50; R. Clifford-Jones, c, 39; T. Rees, b, 0; H. Danford, c, 42; R. Burns (not out), 8; S. O'Keefe, b, 4; J. Ramsey did not bat. Extras, 23. Total, 230 for 9 declared.

St. Mary's—R. Evans, c Langdon, b Goodhart, 23; C. Rance, c Ramsay, b Goodhart, 12; K. Macleod (run out), 7; P. Goodwin, c Evans, b O'Keefe, 31; J. Shueerson, c Langdon, b Goodhart, 15; R. Williams, c Evans, b Danford, 17; J. Bulow, c and b Goodhart, 91; R. Moston (run out), 19; K. Nightingale (not out), 6; J. Vaughn (not out), 3; M. Collwin did not bat. Extras 7, total 231 for 8.

C. LANGDON.

HOSPITAL INFORMATION

GUY'S HOSPITAL BOARD OF GOVERNORS

Applications are invited for the appointment of **Locum Senior House Officer** in Physical Medicine and Rheumatology to the Hume Kendall Unit (Guy's/New Cross Rheumatology Unit) from 1st October, 1971 to 31st December, 1971. Applications with the names of two referees or enclosing two recent testimonials are obtainable from and should be returned to the Superintendent, Guy's Hospital, London S.E.1. not later than **23rd July, 1971.**

JOINT APPOINTMENT AT THAMESMEAD

An integrated health service embracing all three branches of the NHS is being provided for the new community of Thamesmead (between Woolwich and Erith) which will have an eventual population of 60,000. Combined GDS/LHA services are now being provided from a temporary health centre until the permanent centre opens in 1972.

There will shortly be a vacancy for a **Part-Time Dental Practitioner** to work on a sessional basis (health centre rates).

Further information may be obtained from the Department of General Practice, Guy's Hospital Medical School (ext. 570) or from The Clerk, S.E. London, and Kent Executive Council, Station Road, Maidstone.

AMENDED ADVERTISEMENT

Applications are invited for the post of **Senior House Officer** with duties in the Department of Oral Surgery and the Dental Department for Children, to commence on 1st August, 1971 or as soon thereafter as possible, which will be for six months in the first instance. This post is recognised under the regulations for the Fellowship in Dental Surgery of the Royal College of Surgeons of England. Application forms are obtainable from and should be returned to the Superintendent, Guy's Hospital, London, S.E.1, not later than **20th July, 1971.**

PASS LIST

UNIVERSITY OF LONDON
M.D.

J. A. Child
H. Keen

Ph.D.

P. Cresswell
K. Mashiter

UNIVERSITY OF OXFORD
D.M.

S. Nurick
G. S. Spathis

ROYAL COLLEGE OF PATHOLOGISTS
Final Examination

A. Stevens

ROYAL COLLEGE OF SURGEONS OF ENGLAND
Primary F.R.C.S.

P. J. Davenport
J. Hibbert
C. R. G. Quick
M. Sutton
C. G. H. West

PERSONAL

WANTED—Opportunity in New Zealend for Doctor to enter general practice with a local hospital appointment. Obstetrics or surgery essential. Applicant could enter either solo or in partnership. No goodwill required. Accommodation available. For further details write to Dr. C. D. Chilvers, Box 14, Wairoa, Hawkes Bay, New Zealand.

CHANGES OF ADDRESS

Bill and Sheila Bunting, 20 Cypress Drive, Exwick, Exeter. Tel: Exeter 57486.

W. F. Dobson, Esq., L.D.S., R.C.S., "Pantiles," 154, Lower Green Road, Esher, Surrey.

Dr. R. G. Bury, 43, Fitzroy Crescent, South Hobart, Tasmania, Australia.

Dr. and Mrs. Edward Bowen Jones, 30, Cavendish Gardens, West Didsbury, Manchester 20. Tel: 061-445 8111 ext. 513

Mr. and Mrs. M. J. Lightfoot, Moat Farm House, Chevington, Bury St. Edmunds, Suffolk.

BIRTHS

BROOK—On 28th March, at Cambridge Maternity Hospital, to Pamela (née Barnardo, S.R.N.) and Dr. Simon Brook, a son, Jeremy David, a brother for Claire, Andrew and Timothy.

DAVIS—Liz (née Pullom) and Tony Davis had their first child, a daughter, Rebecca Claire, on Wednesday, 23rd June, 1971.

HUGHES—On 17th June, to Coral (née Whittaker) and Richard Hughes, a daughter, Romany Clare, sister for Polly Nicola.

NORTON—(Dr. June Brett) On 13th May, 1971, to June and John Norton, a daughter, Katharine Ruth, a sister for Anne and Richard.

ROWLAND—To Ann and Dr. Chris Rowland, on 25th May, 1971, twin daughters, Myfanwy and Tanya, sisters for Caroline and Nicola.

GUY'S HOSPITAL GAZETTE

EDITORS N. D. S. BAX and A. M. TURNER
NEWS EDITORS R. M. DARLING and J. L. LEWIS
SPORTS CORRESPONDENT A. M. ROYSTON
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TEN PENCE VOLUME 85 NUMBER 2167

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Of Cabbages and Weeds

Magic of varying kinds, seems a necessary and all-important force in life. There is much around to prove this. One particular seemingly innocuous branch of magic is that of herbalism. That is not to say that many such preparations may not be most efficacious; it is just that controlled trials have not come to herbalism.

With the right publicity-men and sponsors, Macbeth's three witches would undoubtedly be pleasantly rich. Certainly a small group of people are at present making money out of other's gullibility. The peripheries of medicine have always attracted charlatans in addition to well-intentioned people, but the services they can offer, especially in herbalism, have for the most part now been bettered by drugs of proven worth.

Many health food shops, places that are becoming increasingly popular, sell, in addition to foodstuffs, herbal remedies. Couch grass may be a remedy for urinary tract infections but most of us would prefer to be treated with antibiotics. As does happen, somebody goes to one of these shops and tells the service staff of their problem. Often a quick and unproven diagnosis is made and the customer sold a remedy. Often, too, it appears that the same mixture of herbs is good for everything from clear skin to bladder infections. Instead of telling the customer to go to their doctor the sales assistant is more motivated by money than humanity, which is natural due to the nature of her job. It is a dangerous and potentially lethal rôle that the assistant plays. But the shops are called "Health Shops" or the like, so all must be well.

Professor Butterfield showed in a Bermondsey survey the incredible number of people who treat themselves and the variety of useless things that are used. Nowadays some "health" shops exploit people's natural fear of real medicine and doctors in particular perhaps, by offering a mixture of smooth talk and unproved, untested and medieval remedies.

It would be a bad thing if there was not the Committee for the Safety of Drugs, which to some extent protects patients from drugs whose dangers outweigh their usefulness. It is equally appalling that remedies can be sold that have no known beneficial effect and may indirectly cause the worsening of a person's condition. It seems unlikely that one could ever legislate against remedies sold in health food shops, because people will always believe in magic.

The Rites of the Unmarried

Dr. R. R. Williams, Bishop of Leicester, yesterday called doctors to come off the fence, an age-old seat of discomfort, and advise young people against sexual experimentation before they are married. His reasoning is that doctors are regarded as authorities of the twentieth century culture of science, priests of the new denomination, and are therefore given a more respectful hearing than is his profession. It would be interesting to discuss why his calling is unrelated to the common people but at present the debate concerns the moral argument for and against pre-marital sexual intercourse.

The taboo, and in that word lies the implications of the problem, against sexual intercourse before or outside the marriage union grew up long ago as a protective mechanism for the offspring. Children require protection to allow them to develop to healthy workers. From studies of so-called primitive races and tribes it would appear that most concluded that the men and women of child-bearing age should join into a formal protected and socially welcome couple, or pair-bond as it is rather offensively known in functional biological circles. Taboos grew with the formalisation as a protection and were the origin of our social conventions which nourish the married couple. But here taboos and customs are in no way sacred. The Wakamba tribe in East Atrica forbid girls between the times of puberty and their marriage to see their fathers because of a fear of incest. In another African tribe children before the age of puberty are put together into a hut and taught the game of making love, which helps them lose their inhibitions with their bodies. The two sexes are then separated after puberty.

We are gradually losing the taboo against intermarriage between members of races with different skin colour. The period of change, when some people lose their dread of the unknown, their craving for the familiar, and challenge what they consider meaningless social convention is bound to be turbulent and unhappy for many. The problem is acute at present in the matter of young people and pre-marital sexual relations. With extensive use of the almost completely effective contraceptive pill the need to protect children against casual sexual relationships would disappear. The present hideous predicament in which young people have caught the notion that pre-marital sexual intercourse is not wrong from basic moral principles but have not extensively adopted the practice which has released them from the prohibition is solved perhaps not by returning to the taboo but by educating in the sensible use of contraceptives.

There are still the arguments that premature sexual relationships are harmful to the personalities involved, more harmful even than abstinence from sexual experience. Young people suffer from feelings of insecurity if they are not indulging in the sexual relationships that their friends have. They are inexperienced at the moment in dealing with relationships that no one has shown them how to deal with; sexual experience has been the prerogative only of married couples in their parents' generation. Although youngsters do not see it as signifying a permanent bond, their cultural training so far has taught them that and it is difficult to realise the significance of the physical act in this state of confusion. If the veneration of the virgin and the taboo of pre-marital intercourse is lost, those problems largely disappear since the act has much less significance.

Venereal diseases remain as an increasingly intractable problem. They are certainly the current most potent reason to discourage promiscuity, but that is a separate issue from pre-marital sexual intercourse.

Arguments by analogy of how different races behave, of course, are no final solution to the way we ought to conduct our lives. This is England. The point is, however, that those societies are not particularly ill societies compared with ours. The physician's rôle is to recommend courses of action to deal with disease. If society can organise itself to cope with the change from one behaviour pattern to the next, it is not the position of the physician to deny it that right. He is entitled to his private judgment but as a professional he must deal only with disease.

Of course the Bishop of Leicester is right that at present we have a painful confusion of attitudes, but the medical profession can only estrange itself from society if it steps beyond its confines and attempts to play a different part. If we must persist with these painful metaphors, doctors must remain on the spiky fence.

NEWS IN BRIEF

White Coats for Students

Guy's is the only London teaching hospital in which clinical medical students do not wear white coats. This situation has been the subject of discussion in the past, and the question has recently been raised again. The last occasion on which there was serious discussion about the subject was about three years ago. Written records of those discussions have unfortunately been lost, but the following account has been gathered from hazy memories.

It was decided that for a trial period of three months, students could wear white coats if they so desired. Students were to be responsible for the purchase and laundry of the coats and two clean coats were to be worn each week. The possibility of bulk buying of coats was investigated, but for some reason ran into problems. Laundering also posed a problem : the hospital laundry would not have been able to cope with the extra numbers involved, and although a local laundry agreed to launder coats at a reduced rate if a certain minimum number of coats could be supplied each week, this number was not achieved and the agreement lapsed. It was also decided that white coats could be worn only on the wards, and not in the Park or the Spit. With all these restrictions, it was perhaps not surprising that very few clinical students invested in white coats.

Any new campaign about the wearing of white coats by students needs evidence to back up its claims, and constructive suggestions for overcoming the problems which could not be surmounted in the past. With this in mind, a survey has been carried out of the London teaching hospitals :—

	Are white coats worn on wards?	Are they compulsory?	Length half or full	Are they supplied by the hospital?	Does the hospital launder them?	Are white coats restricted to the wards?	Are name badges worn?
Royal Free	Yes	Yes	Half	No	Yes (cost 4p)	Yes	Sometimes
King's	Yes	Yes	Full	Only for Residence	Only for Residence	No	Yes
St. George's	Yes	Junior Yes Senior No	Full	No	Yes	Yes	Yes
Middlesex	Yes		Half	Yes	Yes	No	Yes
St. Bartholomew's	Yes	Yes	Full	No	Yes	No	Yes
London	Yes	Yes	Full	No	Yes	No	Yes
U.C.H.	Yes	Yes	Half Male Full Female	No	Not Yet Soon Hopefully	No	Yes
St. Thomas's	Yes		Half				
Westminster	Yes	Yes	Half	No	No	No	Yes
St. Mary's	Yes	Yes	Half	No	Yes	No	Yes

(Compiled by Lynne Hampson)

It can be seen that Guy's stands alone as the bastion of the good old days of medicine for gentlemen, when surgeons operated in blood-caked frock coats. Although a desire for conformity should not be a reason for change, the possibility should be considered that the other hospitals have adopted white coats for good reasons. The original decision to allow white coats for a short trial period was doomed to failure, for few students were prepared to invest in three or four white coats which they were allowed to use for only three months. If a new decision is taken to make students wear white coats, a trial period has no useful function. With regard to purchase and laundry of coats, it would obviously be to the students' advantage if part or all of the cost of purchase and laundry were met by the Medical School. If this were not forthcoming, however, a sufficient number of coats to provide two clean coats per week could be purchased for well under £10, and laundry costs should not exceed £10 p.a. Against this would be offset the purchase price of the suits and jackets which are needed at present, and their dry-cleaning costs. Thus, even if students had to bear the whole cost of white coats and their laundry, there would be no extra financial burden when compared with the maintenance of suits. In fact, it may be cheaper in the long term.

The decision three years ago to limit the wearing of white coats to the wards was rather impractical, to say the least. Not only are there no facilities on the wards for hanging jackets or coats, so that students would have had to take off their white coats and carry them to their lockers, but in addition, the ban on wearing white coats in the Spit ignored the fact that there are only limited facilities in the East Wing for hanging white coats. The argument that if white coats could be worn anywhere they might act as carriers of infection can also be dismissed: the jackets which are worn at the moment are no less likely to transmit infection, are cleaned less frequently than white coats would be, and are worn in areas such as trains or at football matches. Thus white coats are in fact less likely to transmit infection, unless, of course, micro-organisms have a particular predilection for them.

A further argument against white coats for students is that they are likely to lead to patients confusing students with housemen. This could be simply overcome by issuing students with name badges of a different colour to the housemen's. As the survey shows, Guy's is one of the few London teaching hospitals not to have name badges for students.

In summary, it seems that white coats would be of benefit not only to students but also to the Hospital. Perhaps there are also arguments for consultants and registrars wearing white coats?

Correspondence on the subject would be welcomed.

Technicians' Strike

On Thursday, 22nd July, there was a one-day strike by the Association of Scientific and Technical Managerial Staffs (ASTMS), whose membership includes hospital laboratory technicians, as a protest against a recent pay award. A work-to-rule was also started on Monday, 19th July, which is to continue indefinitely.

The origins of the strike go back to April, 1970, when a claim for a 25 per cent pay increase was submitted to the Department of Health and Social Security, who awarded a 15 per cent pay increase with the promise of a later revaluation. A working party was set up by the Whitley Council, which represents management, i.e. the Department, and staff, represented by four unions: ASTMS; NALGO (National Association of Local Government Officers, composed of clerical and administrative staff); COHSE (Confederation of Health Service Employees, composed of porters, mental hospital nurses, etc.); and NUPE (National Union of Public Employees, representing porters, cleaners, etc.). The reports produced by the two sides of the working party conflicted in certain areas, but negotiations were restarted, and led to a pay offer in December, 1970. This offered salary increases of up to £432 p.a. at the top of the seniority scale, but proportionately far less to the junior grades, e.g. no increase in salary for Student Technicians, and £2 p.a. to Technicians with Higher National Certificate. ASTMS object to this, claiming that it does nothing to encourage recruitment into the profession. A junior cardiology technician, for example, may start at a salary of only £330 p.a. Although ASTMS has five times as many members as the combined membership of the other three unions represented on the Whitley Council, there is not a corresponding representation with regard to voting power, and when the other three unions voted to accept the pay offer, ASTMS were outvoted. The Department have authorised the pay agreement in spite of further representations by the ASTMS, who therefore called the work-to-rule and strike.

The union had hoped that the strike would paralyse all routine laboratory work, although they undertook to cover emergencies. At Guy's, the strike seems to have had little effect on the routine functioning of the laboratories. In most laboratories only a few technicians went out, and in one laboratory the technicians did all the routine work in the morning and went on strike in the afternoon. The work-to-rule will mean that technicians will not, for example, service or repair equipment themselves, as they usually do, but will call in service engineers. In view of the negligible impact of the strike, it seems unlikely that the work-to-rule will have much effect, which is a pity for the ASTMS, who seem to have a real grievance.

Student Feed-back

After a recent surgical firm dinner, the consultant, lecturer, both registrars and both housemen was incapacitated by gastroenteritis. None of the students were affected. Perhaps this is the much-hunted type 5 Immune Reaction—"De immunitate prandii Spitorum".

The Sick Spit

Discontent with the catering in the Spit has been mounting over several months and recently culminated in profuse correspondence in the columns of the *Gazette*. Shortly afterwards, intensive enquiries were started to find out the students' main grumbles and the best way of alleviating them. J. Buckley and Miss J. Leithead, who are the representatives of the Students' Club Council who sit on the Catering Sub-Committee, devised and circulated a questionnaire to the Student Body. About 750 were sent out and 245 were returned. Although it was neither unbiased nor comprehensive, it was readily seen from the replies that students were dissatisfied with the quality of the food and wanted to see more snack items on the menu.

The results were presented to the Catering Sub-Committee of the Medical School Council. It was decided to provide more snacks and to have fewer standard items on the menu. The price scale was altered to allow more choice as regards vegetables and a suggestion box was installed near the till. An informal committee, consisting of Mr. Bompas (Medical School Secretary), Professor Hunt, Miss Redsell (Catering Manageress), a representative from the Residents and Miss Leithead and Mr. Buckley, was set up to maintain closer contact with student views. Recently, a catering expert from Lyons spent some time observing various aspects of the Spit, including purchase of food, deployment of staff and the use of facilities. He is expected to report to the Catering Sub-Committee in September.

It is too soon to predict the effect of the changes on the business turnover in the Spit. However, Mr. Schultzberger may find it comforting that his plea from the gut (*Gazette*, 8th May, 1971) did not go unheaded.

Guy's Blind Eye

A few weeks ago a pair of trousers, whose pockets contained money to the value of a few pounds, was found draped over the front railings of Guy's. If the owner would like to get in touch with Mr. Evans, the security officer, his trousers will be returned with no embarrassing questions asked.

Follies Thamesmead

The Thamesmead Town Show on Monday, 30th August, desperately needs help from extrovert medical and dental students, nurses, physiotherapists, radiographers and anyone else wishing to help. Information about the antics appears in the correspondence columns.

Acute Infections of the Genito-Urinary Tract

E. Latimer-Sayer

Amongst the mammalian species mankind is unique in the frequency of urinary tract infection. The causes for this difference are largely unknown.

1. The Kidney

Renal infection may arise *de novo,* when it is termed primary, or from another infected lesion in the body or from infected urine, in which case it is termed secondary.

Primary renal infection is due to a haematogenous source. If there is a temporary bacteraemia the normal kidney filters out bacteria from the blood in the cortex, and these may produce small lesions which usually become fully healed in a short time. Occasionally, due to (1) a large number of bacteria, (2) their high degree of virulence, or (3) a reduction in host immunity—as seen commonly in patients with diabetes or on marrow-poisoning drugs—these lesions progress and involve the collecting system and may produce one of the types of renal infection described below.

Secondary renal infection is much more common. It may be due to ascending infection, most commonly from the urethra, bladder or prostate. Here the organisms probably reach the renal interstitial tissue by travelling in the periureteral lymphatics. Organisms from pelvic sepsis or even appendicitis may also use this route to reach the kidney to produce secondary infection. The third way in which organisms may reach the kidney, and the most common, is by the reflux of infected urine. When the uretero-vesical junctions are incompetent, which may be subsequent to bladder infection, congenital anomaly or neurogenic bladder, (Rosenheim 1965, Garrett *et al* 1961), secondary renal infection is almost sure to occur, and usually becomes the cause of death, which gives these patients such a poor prognosis.

There are four types of acute renal infection.

(a) Acute pyelonephritis.

This is the commonest renal disease. In spite of this, only about one in five cases are diagnosed accurately during life (Boyd, 1961). This is because pyelonephritis is one of the great imitators and may present in obscure ways, especially if it becomes chronic, and also because some degree of cystitis is almost always associated and the symptoms from the bladder may overwhelm those of the kidney. If the infection is presumed to have arisen without any other obvious infective lesion anywhere else, this is called primary pyelonephritis but if as mentioned earlier, another infective process is probably the cause then this is called secondary pyelonephritis.

Pyelonephritis may be acute, chronic, or when cured, is spoken of as healed. Chronic pyelonephritis usually follows two or more attacks of acute pyelonephritis but it can begin insidiously. It is the commonest cause of death from renal failure and about 36 per cent of cases of chronic pyelonephritis die from renal failure (Boyd 1961).

Acute pyelonephritis is a focal supperative infection of the interstitial tissue of the kidney and renal pelvis. The acute process usually clears up but it may become chronic with acute exacerbations. In the acute stage as a rule both kidneys are involved, although the extent of the lesions can vary considerably on each side. Macroscopically the kidneys are swollen and congested, the pelvis is bright red and filled with pus. Under the capsule are many little yellow spots representing areas of suppuration, as well as irregular patches which form the bases of wedge shaped areas in the renal substance. The cut surface shows patchy areas of suppuration, which tend to be spherical in the cortex and linear in the medulla. If suppuration is progressive, abscess cavities are formed, with gradual reduction of renal tissue. The outline of the calyces is destroyed and the resulting distortion seen on an I.V.U. is important for clinical diagnosis.

By far the commonest organism is E. coli which causes over 50 per cent of cases in hospital and even more in domiciliary practice. Other organisms which are found commonly include Klebsiella, Proteus, Pseudomonas, Staphylococci and Streptococci (both haemolytic and S. faecalis).

The aetiology of secondary pyelonephritis varies with the age and sex of the patient. In children, it is commoner in girls and statistically is associated with the high incidence in girls of asymptomatic bacilluria (Kunin *et al,* 1964) which is presumed to be caused by the possession of a short urethra. Lack of prostatic secretion may also be a factor as it contains a bacteriocidal substance (Stamey *et al,* 1968).

However, in boys it is often caused by hitherto asymptomatic and unsuspected congenital anomaly such as urethral obstruction due perhaps to urethral valves or a ureteric anomaly allowing reflux. In young women, the commonest cause of secondary pyelonephritis is pregnancy and, as in young girls, a great excess in cases is seen in the asymptomatic bacilluria group (Kass, 1960).

The gravid uterus may act in two ways: first the mechanical effect of a pelvic tumor which may cause partial urinary retention in the bladder and may also press on the ureters as they cross the pelvic brim, and secondly the effect of progesterone on the ureteric muscle which causes the ureters to dilate and become relatively atonic. Also in this age-group large ovarian tumors may affect the mechanics of the urinary transport system.

In young men, infections of and injuries to the urethra are the commonest initial nidus of infection because this may go on to stricture formation, and therefore predispose to urinary stasis and ascending infection.

Over the age of 50 years, urinary stasis, which in men may be caused by low urinary obstruction from prostatitis, benign hypertrophy of the prostate, or urethral stricture, or which in women may be caused by prolapse of the uterus, or cancer, especially of the cervix, causes ascending infection and secondary pyelonephritis.

Diabetes in all age-groups predisposes to both primary and secondary pyelonephritis because organisms grow well in glycosuric urine, and diabetics have reduced immunity and healing and are especially prone to focal infection.

(b) **Pyonephrosis.**

This occurs when either a pyelonephritis becomes complicated by an element of obstruction, which may be due to inflammatory oedema in the ureter or pelvis, or where a hydronephrotic kidney becomes the seat of a pyelonephritis. Anyway, the net effect of an obstruction to urinary flow and an acute infection is to convert the kidney into a bag of pus. Such a kidney becomes much enlarged, the surface irregularly lobulated, and when it is opened it shows large abscess cavities with just a shell of renal tissue left.

Experiments in animals have shown that if an acute stasis of urine is produced by clamping the ureter, infection of the renal substance above is almost sure to occur. Release of the obstruction after a few days induces healing of the pyelonephritic process (Mallory *et al,* 1940). In man the question of whether a blood infection will cause unilateral or bilateral renal lesions is probably largely determined by the presence of obstruction.

(c) **Perinephric abscess.**

This is a localised suppuration in the perinephric tissue, usually due to S. aureus, which may have come initially from a boil or carbuncle in the skin. Sometimes a perinephric abscess is seen as a complication of acute pyelonephritis; the most usual site is posterior to the kidney.

(d) **The pyaemic kidney.**

This is a renal manifestation of a general pyaemia, in which abscesses are formed in many organs including the kidneys. The organism is usually a Staphylococcus or a haemolytic Streptococcus and this lesion is usually only seen as a terminal event in an overwhelming septicaemia. It used to be very common.

The clinical picture of renal infection depends on the chronicity of the disease. In acute cases there is usually pain and tenderness over the loins, pyrexia, leukocytosis, and urinary changes, including pyuria, haematuria and bacilluria. Urinary frequency and dysuria are commonly seen due to associated cystitis. If a perirenal abscess has formed then oedema and reddening may be seen in the loins and the fever may become typical of an abscess. The patient with acute renal infection often shows a marked toxaemia, and may look and feel much more ill than the minor lesion he may have would warrant.

This effect may be due to the fact that the lymphatics from the kidney drain directly into the thoracic duct, often without any intervening lymph nodes. Thus large amounts of bacterial toxins and infective material may enter the systemic blood. Many patients with acute pyelonephritis may present as an abdominal emergency, especially if they are pregnant, with acute severe lateral abdominal pain, followed by a rigor, and they may then become shocked.

The history is important to rule out previous infections elsewhere that may have acted as a primary source, or there may be evidence of some other pathology in the urinary transport system such as prostatic disease.

Diagnosis during an acute infection is usually made by history and examination, coupled with careful examination and culture of early morning and mid-stream urines.

Patients may be allowed to have one attack of acute pyelonephritis (except children) but if they have another attack a thorough investigation of the urinary tract is indicated and this ought to include :

(a) An I.V.U. which would help to show urethral or ureteral stricture, impassable stones, or suspected anomalies, and also gives a good guide to differential renal function.

(b) A cystogram which will show the size and shape of the bladder and also its location. If the bladder is afflicted by chronic cystitis it may be small and spastic, or it may be atonic. It may be displaced from its normal position by a pelvic tumor, or may show filling defects due to ureterocoele, enlarged prostate or a tumor. Also the amount of residual contrast medium after micturition may be assessed, and also if there is ureteric reflux.

(c) Cystoscopy and perhaps panendoscopy, and occasionally a retrograde pyelogram. However, pyelonephritis is itself a possible complication from this procedure so that it should not be undertaken lightly.

The treatment of acute pyelonephritis includes general supportive therapy, specific antibiotics for the infective organism, bed-rest, and a high fluid intake. This should be carried out in hospital as these patients may suddenly become very ill and require skilled attention. Afterwards, if indicated, urinary tract disease or deformity must be corrected.

The prognosis in acute pyelonephritis is excellent, the attack usually lasting only one or two weeks so that any form of treatment gives good results. However, the major complication, chronic pyelonephritis is an entirely different matter and therefore the great need to investigate fully any adult who has had two or more attacks, or any child who has had one attack. The whole aim of treatment is to eradicate acute infection quickly and completely and to prevent recurrence.

2. The Bladder

The bladder plays the part of a halfway stage between the upper and lower urinary tracts, and it therefore runs a double risk of infection. As an offset to this it must be noted that the healthy bladder is peculiarly resistant to infection. In animals, experimental instillation of virulent bacteria into the bladder produce no disease, the bacteria disappearing very quickly (Norden *et al,* 1968). There is such a good defence mechanism in fact that if infection is found in the bladder the strong probability is that it is not primary to that site.

The bladder depends for its protection from infection on two main factors, first that on micturition the bladder should be completely emptied, thus washing out any bacteria that may have got in after the last emptying before they have had a chance to multiply and produce disease, and secondly that there should be no surface lesions of the mucosa or false pockets or reflux where bacteria may hide when the bladder is emptied. A further important factor is the ability of the mucosa to phagocytose (Vivaldi *et al,* 1965), a few bacteria, or at any rate destroy them in some way, but the method is unknown (Norden *et al,* 1968). The effect of the mucosa is more pronounced when the urine volume is small.

Infection from below in the male is usually due to retention, caused by urethral stricture, prostatic disease, or sometimes by the passage of an infected catheter. In the female it is more likely to be due to infections in the vagina and cervix which may pass up the lumen of the urethra between micturition. These causes of cystitis are especially frequent in young girls and in the elderly.

Infection of the bladder commonly arises from the kidneys above and is associated with acute and chronic renal infections. Predisposing causes in the bladder are: retention of urine with residual urine constantly present, an anatomical abnormality such as diverticulae, or the presence of a stone or a foreign body. The most common infection of the bladder is that due to E. coli, especially if the urine is acid. Other coliform bacteria are more likely if the urine is alkaline as this may be due to the formation of ammonia by urease producing bacteria such as Proteus. Also commonly found are Klebsiella, Pseudomonas and Strep. faecalis. Klebsiella is especially associated with chronic infections.

An important feature of the bacteriology of cystitis is that the flora of the bladder may change with a changed reaction of the urine, thus during treatment the urine must be cultured early and often and the therapy changed if indicated. Another feature is the fact that when the bladder is already infected, opportunist organisms not sensitive to the antibiotic may gain a foothold, so that in the course of one clinical bout of cystitis more than one main organism can cause the disease successively. Thus it becomes important to use broad-spectrum antibiotics.

Acute cystitis is characterised by a swollen, reddened and haemorrhagic mucous membrane. Small ulcers develop, the surface is covered with shreds of epithelium and small clear cysts are formed on the trigone. Microscopically there is congestion of the submucosa and infiltration with inflammatory cells. The superficial layers of mucosa may become desquamated but the main substance of the wall remains intact.

Cystitis is associated with frequency, both night and day, dysuria usually of a burning nature, aching in the suprapubic area and pyuria and significant bacilluria. The concept of significant bacilluria was brought in to solve the problem that because urine is such a good culture medium, and because to collect it aseptically is so awkward, almost all specimens of urine yield some colonies on culture. (Kass 1956, Asscher *et al* 1966). Hence if on high dilution the urine can be shown to have contained more than 100,000 organisms per cub. mm. and if the specimen was cultured immediately or stored at 4°C., then it is most likely that the urine contained bacteria within the bladder. The figure 100,000 per cub. mm. is a purely arbitary number which was decided upon by the evaluation of a large number of counts from patients who were followed up by cystoscopy.

In diagnosing cystitis extravesical sources for the infection should be ruled out, especially from the kidney, as well as vesical tumor, stones and obstructions to urinary flow. Cystoscopy after recurrent cystitis should be done to eliminate treatable diseases and many patients ought to have an I.V.U., especially if it does not clear up quickly or if no prodisposing cause is evident. The volume of residual urine after micturition should be found by catherterisation.

Treatment of acute cystitis is fairly straightforward and involves finding the infecting organisms and giving suitable chemotherapy (Flocks, 1968 (i)). Outside hospital sulphonamides still cure about 80 per cent of cases and should be tried first. If this does not work then Septrin should be tried. Failing this the patient should be referred to hospital for a more thorough diagnostic appraisal and more toxic drugs may need to be given. General measures are bed-rest, and increased fluid intake, and eradicating vaginal or cervical infection if found.

3. The Prostate

Acute prostatitis is quite common, particularly during middle life. It may be due to gonorrhoea or coliform organisms. Sometimes abscesses may be formed. Nearly always prostatitis is part of a posterior urethritis.

Signs and symptoms vary, depending on the organism, the stage of the infection and whether abscesses have formed, but the diagnosis is very often missed as it can present as a 'flu-like illness without localising features. It is usually associated with dysuria and frequency. Acute retention can occur if an abscess forms or if an acutely swollen gland compresses the urethra.

The diagnosis is usually made by eliciting an "ouch" reaction from the tender prostate on rectal examination, and also the two-glass urine test. In less acute cases massage of the prostate may cause a purulent discharge to appear at the tip of the penis and this can be cultured.

The treatment consists of general supportive care, appropriate chemotherapy and drainage if an abscess forms. This disease can be quite severe, and if rigors occur, or the patient becomes obviously distressed he should be nursed in hospital. The Americans advise repeated prostatic massage for less acute cases but there is little evidence that this does much good (Flocks, 1968 (ii)).

4. The Urethra

The only important and commonly occurring acute infection of the urethra is gonococcal urethritis. Other infections do occur such as coliform organisms and non-specific urethritis. Gonorrhoea and the other infections are treated by suitable chemotherapy. For diagnostic purposes the history of sexual contact with a suspect 5–7 days previously, and a Gram stain of the discharge is all that is required.

A late effect of poorly treated gonorrhoea is urethral stricture. The gonococcus is harboured in the glands of Littré which are mucus-secreting glands in the walls and roof of the urethra, and in this site they are immune to antibiotics, allowing a chronic fibrosis to occur.

Symptoms of gonorrhoea are profuse, purulent discharge from the urethra with burning on micturition. A complication of the acute disease is infection of the seminal vesicles, vas deferens, and epididymis with resulting sterlity, and this may also occur with urethritis caused by coliforms.

Non-specific urethritis is a venereal disease of unknown aetiology and is a mild, self-limiting condition which occasionally is associated with arthropathy, skin rashes and iritis.

Any patient with a gonococcal urethritis should be followed up and a Wassermann and Kahn test should be done at 5–6 weeks. In women Trichomoniasis derived from the vagina may cause an acute urethritis and this can be treated with metronidazole.

5. The Penis

Infections of the penis are relatively uncommon, and consist essentially of balanitis, chancre, granuloma inguinale, chancroid and lyphogranuloma venerium. These are all mostly venereal in nature. they are cured by cleanliness and accurate identification of the organism and appropriate chemotherapy. The discharge, if any, should be examined for spirochaetes with dark-ground miscroscopy.

6. The Testes

Acute orchitis may be secondary to infection of the epididymis and cord structures, or it may be primary and not involve them. Primary orchitis is seen most commonly as a result of mumps or Coxsackie virus infection in adult males.

Diagnosis is made by palpating the acutely tender swollen testicle. These have been called "balls of fire" in some circles and this illustrates the extreme discomfort experienced by the patient. Mild cases are treated conservatively and symptomatically, that is bed-rest, analgesics, elevation of the scrotum and ice packs. Severe orchitis is treated by excision and drainage of the tunica vaginalis and albuginea in the hope that this will prevent the severe testicular atrophy which can occur, which, if bilateral, renders the patient sterile.

The major complication of viral orchitis is sterility, and there is really little one can do to prevent this.

7. The Epididymis, Vas Deferens, and Seminal Vesicles

Infections here can be gonococcal or coliform in origin, and the pathogenesis and treatment of both types of infection are generally the same. They are usually secondary to infection of the lower urinary tract from prostatitis, urethral manipulation, or too vigorous prostatic massage. Diagnosis is made by palpation of the inflamed genital tract, and there may or may not be an associated orchitis.

Accompanying these local signs may be chills, fever, sometimes rigors, and a leukocytosis. There is often a recent history of a urethral discharge which may be a helpful diagnostic point. Treatment is by chemotherapy after identifying the organism, and by the eradication of the initial focus of infection before the other side becomes involved and causes the almost inevitable sterility.

8. Vulvo-vaginitis

This is common in epidemic form in girls when it can be due to a non-venereal gonococcal infection. The treatment is the same as any other form of gonorrhoea. Some adult women may develop an acute Bartholinitis as a result of venereal infection with the gonococcus; this is more difficult to treat and often becomes chronic when marsupialisation of the gland is necessary.

Another cause is Trichomoniasis, which is especially common in pregnancy. It presents as vulval pruritis accompanied by a profuse seropurulent discharge containing bubbles. Microscopically, the discharge is loaded with bacteria and flagellate organisms. This condition is usually treated with metronidazole.

The soft chancre is an acute inflammatory venereal lesion which may produce multiple small ulcers over the vulva. They are shallow and not indurated. There is a marked tendency to form suppurating bubos in the groin. It is eradicated by chemotherapy which is usually streptomycin or chlortetracycline.

Lastly, gangrenous vulvitis, which is a rare but dangerous event in debilitated children, and is caused by a mixed infection with streptococci and other organisms. Spreading gangrene occurs with severe toxaemia, but it may respond to antibiotics.

References.

1. Rosenheim, M. L. (1965) Vesico-ureteric reflux, in Progress in Pyelonephritis ed. E. H. Kass and F. A. Davies, Philadelphia. p. 599.

2. Garrett, R. A., Rhamy, R. K., and Carr, J. R. (1961). Non-obstructive vesico-ureteral regurgitation. *Trans. Amer. Assn. Genitourin. Surg.* **53**, 120.

3. Boyd, W. (1961). Text-book of Pathology, 7th edition. Diseases of the Renal Interstitial Tissue. p. 584.

4. Kunin, C. M., Deutscher, R., and Paquin, A. (1964). Urinary Tract Infection in Schoolchildren. *Medicine*, **43**, 91.

5. Stamey, T. A., Fair, W. R., Timothy, M. M., and Clung, H. K. (1968). Antibacterial nature of prostatic fluid. *Nature*, London, **218**, 1444.

6. Kass E. H. (1960). The role of asymptomatic bacilluria in pathogenesis of pyelonephritis in Biology of Pyelonphritis.

7. Mallory, G. K., Crane, A. R., and Edwards, J. D. (1940), *Arch. Path.*, **30**, 330.

8. Norden, C. W., Green, G. M. and Kass, E. H. (1968). Antibacterial mechanisms in the urinary bladder, *J. clin. invest.*, **47**, 2689.

9. Vivaldi, E., Munoz, J., Cotran, R. and Kass, E. H. (1965). Factors affecting the clearance of bacteria within the urinary tract in Progress in Pyelonephritis ed E. H. Kass and F. A. Davies, Philadelphia, p. 531.

10. Kass, E. H. (1956). Asymptomatic infections of the urinary tract. *Trans. Assn. Amer. Phsns.*, **69**, 56.

11. Asscher, A. W., Sussman, M., Waters, W. E., Davies, R. H., and Chick, S. (1966). Urine as a medium for bacterial growth. *Lancet*, **2**, 1037.

12. Flocks, R. H. (1968). Inflammatory disease of the bladder in Synopsis of Surgery, ed. R. D. Liechty and R. T. Soper, C. V. Mosby & Co., Saint-Louis, p. 935.

13. Flocks, R. H. (1968). Inflammatory disease of the prostate in Synopsis of Surgery, ed. R. D. Liechty and R. T. Soper. C. V. Mosby & Co., Saint-Louis. p. 942.

E. Latimer-Sayer is a Clinical Medical Student at Guy's.

The Address at the Memorial Service
for

The Late Sir Heneage Ogilvie

given by
Professor Sir Hedley Atkins

William Heneage Ogilvie died on 15th April, at the age of 83. Since his death many obituaries in the national and the medical press have extolled his virtues as a surgeon and have recited becomingly his appointments and his many great distinctions. On this occasion, and in Guy's Hospital, which was his surgical home, which he dearly loved and to which he was ever grateful, it is more appropriate to recall him as a man and it is this that I shall try to do. Try, I say, because Heneage was one of the most complex yet lovable characters that I have known. When I first came to Guy's he was the junior assistant surgeon, but his reputation as a teacher of most original and stimulating quality, carried over from his days as registrar and demonstrator of anatomy, had already made him a magnet which drew those men within his circle who wished not only to learn how to become surgically educated, but to delight in the manner of his teaching—witty, trenchant and original.

Heneage, tall and distinguished-looking, attributes of which he seemed genuinely unaware, bestrode the surgical world of Guy's an intellectual giant. In speech and writing he was fastidious in his choice of words so that his books and his essays on life in general will no doubt keep his memory alive when his more original but unorthodox theories on surgery, thrown out to stimulate discussion, have become but objects of historical interest. Heneage was a pupil of Arbuthnot Lane and a lifelong admirer of Lord Moynihan, so that the art of gentle surgery advocated by these men was advanced at Guy's, to the immense benefit of those who came after him and to the salvation of his and their patients.

One of Heneage's most delightful attributes was his ability to get up at a moment's notice and "say a few words" of thanks or welcome, the most difficult of assignments, which he so readily achieved with grace and felicity. He was immensely gregarious and loved to surround himself with young people of candour and spirit, whom he would entrance with anecdotes and enlighten with the wisdom of experience. He was, therefore, the ideal presiding genius of the Surgical Travellers' Club which he founded in 1927 and which now for nearly half-a-century has brought together surgeons from all over Britain for the purpose of journeying to clinics both at home and abroad and for the mutual exchange of ideas.

Heneage loved life and adventure; he genuinely enjoyed his experiences in three wars—the Balkan War of 1912 and the two great world wars in the last of which he achieved highest distinction for his outstanding services. If he loved, he could also hate and he hated

bigotry, pomposity and humbug. Indeed, Heneage never minced words and when used in combat with his *bêtes noires* his observations tended to trespass on the outrageous.

His love of adventure took him to the sea and in all manner of craft both orthodox and heterodox he would enjoy himself in the sunshine and the rain with a host of friends and boon companions who would listen to his ingenious theories of the behaviour of wind and water just as his students listened on his rounds and out-patients in the hospital.

So for his virtues as well as his foibles Heneage was loved and admired. I have left to the last what was, perhaps, his most endearing virtue—his open, warm and generous heart. To his house-surgeons and his registrars he was immensely kind, he would entertain them and feast them; he would introduce them to the great men in surgery with whom he was on familiar terms; he would take them sailing at Burnham-on-Crouch and terrify them.

As one who, when a young man, enjoyed and valued these encounters, who will never forget the fun which he radiated, the courage which he displayed and his dignity in misfortune, I feel privileged to have been invited to give this address and to say farewell and a fair wind to my old friend and teacher.

NOTICE

Guy's—St. Thomas's Medical History Prize

The subject of this prize for 1971 is :—

"THE DEVELOPMENT OF ANCILLARY AIDS TO SURGERY AT ST. THOMAS'S AND GUY'S HOSPITALS IN THE 19th AND 20th CENTURIES."

Entries are invited from **undergraduates** and **junior hospital staff** from Guy's and St. Thomas's in the form of an illustrated essay of a length suitable for subsequent publication in a professional journal.

There is a prize of £20, together with life membership of the Faculty of History of Medicine and Pharmacy offered by the Society of Apothecaries.

The closing date for entries is **31st December, 1971,** and should be submitted to the Medical School Office, Guy's Hospital Medical School.

The prize was won by Mr. B. T. Jackson, a Senior Surgical Registrar at St. Thomas's in 1970.

REVIEW:

Guy's Hospital Theatre Club Summer Production—

Three One-Act Plays

In one of its most imaginative and ambitious programmes to date, the Theatre Club presented us with an evening's excursion into Theatre of the Absurd. It was, on the whole, a successful excursion, even if the reaction of one or two members of the audience might be summed up as "I've heard of Theatre of the Absurd—but this is ridiculous!"

Incredibly, though, audiences were disappointingly low—while Guy's was littered with unoccupied students, nurses and staff, few had the simple gumption or imagination to bother to attend one of the best evening's entertainment available. The apathy and sheer intellectual inertia of the bulk of those at Guy's, has to be seen to be believed.

I. THE BALD PRIMA DONNA, by Eugène Ionesco.

This play had its première in 1950, at which time the Theatre Critic of Le Figaro assured his readers that the author of this play would never be heard of again. Indeed, it did seem unlikely. This play and its successor, *The Chairs,* met an outraged reception. In Brussels, the first-night audience demanded its money back and threatened to lynch the actors; in Milan it was booed off the stage. Yet Eugène Ionesco, born in Rumania in 1912 but living most of his life in Paris, has come to be recognised along with Samuel Beckett and Jean Genet, as one of the greatest dramatists living and writing in France.

The Bald Prima Donna came to England quite late, during the period of revived interest in Ionesco in 1956. It takes place in England, probably because Ionesco conceived the idea of it while taking a course in English. In this course, he learnt many delightful and enthralling things about life in England—such as that one walks on one's feet, but that one keeps warm with the aid of coal and electricity; that the days of the week are Monday, Tuesday, Wednesday, Thursday, Friday, Saturday and Sunday; and that the floor is beneath us, the ceiling above us. Thus, from the felicities of an English phrase book, the Bald Prima Donna was born. He appears not to have reached the lesson in which one learns how to announce that the postilion has been struck by lightning, or no doubt the postilion would have joined the cast!

Those of us whose thoughts have ever wandered during a Latin or French lesson on to the sheer futility of it all—will be familiar with the territory. In an agreeable reaction to the high-flown rhetoric of so much French drama of the preceding years, he reduces his vocabulary to the bare minimum, paring the language down to a purified, abstract state. Ionesco, like Jarry before him, gives us

everyday grammar-book speech, with cliché heightened to a palpable degree. Periodically, though, the thin, crisp shell of sense cracks, and beneath the calm chat, the abyss yawns—we plunge into the hollow that normally lurks just below the conversational level. Again and again the play touches on reality, in this strange, ordinary English household—only to skid past into some state beyond reality. We are on the other side of the looking-glass, with Alice—but the view is not so cosy or comfortable as Wonderland.

In his other plays, physical things—chairs and furniture in *The Chairs* and *The New Tenant*, and the corpse in *Amédee*—intrude more and more upon the protagonists, until the crushing presence of *things* nearly stifles them. In this play, the sheer words threaten to engulf the family.

So it is a tragic farce, for the characters won't realise their metaphysical unhappiness, the stupidity and emptiness of their lives. We are not all that far from the schizophrenia of the Ronnie Laing school—ontological insecurity rears its ugly head on all sides.

One can find fault with the play, for all its significance as a theatrical departure. In Ionesco, ridicule of logic is a running gag—which runs just a bit too long. Even N. F. Simpson can sustain a flight of fancy more confidently. The rapid spray of words and images does not always come off, especially towards the end. In such a setting they should always, even when apparently random, spark, illuminate and display each other—otherwise we have merely a sort of Brownian movement among words, like Gertrude Stein at her greasy worst.

In this very accomplished production, characterisation contributed a lot towards avoiding that danger. Rudi Bilous ("can't control himself when he's bored stiff") played Mr. Smith as an archetypal Dirty Old Man—a convincing performance which suggested considerable experience in the field, or powers of observation beyond the ordinary! Anne Rogers made a perfect 1950 Hausfrau, graceful and natural. David Dunne played Mr. Martin as an up-country engenue with "extraordinary" grace; and Reana Davidson as Mrs. Martin, was very competent, though perhaps a bit more uneasy than the part demanded. Mary Davies was a triumph as Mary, the Maid—a flashy Welsh dresser of great style, sensual and steaming with fiery promise. Stephen Lange, as the Fire Chief, made a bumbling, gentle figure of great appeal. The Clock was the most outspoken character in the play. Keith Freeman is to be congratulated on an excellent production of a difficult work.

II. THE ZOO STORY, by Edward Albee.

Edward Albee, probably known to most people as the author of "Who's Afraid of Virginia Woolf?", also began as a contributor to Theatre of the Absurd. Zoo Story, first produced in West Berlin in 1959, was hailed as a Work of Social Criticism; a Savage Attack on the American Way of Life. But despite this, it was a good play. It is also an absurd play, on the face of it, though it retreats from the implications of the absurd—a failure of nerve compared to

Ionesco. Albee still accepts the validity of reason, and does not lose sight of theatrical conventions.

Albee never quite grasps the significance of the absurd, as does, for instance, Jean Paul Sartre: "Une geste, un événement dans le petit monde calorié des hommes n'est jamais absurde que relativement; pour rapport aux circumstances que l'accompagment les discourse d'un fou, par exemple, sont absurdes par rapport à la situation ou il se trauve mais non par rapport à son délire. *(La Nausée). To be truly absurd is a highly intellectual act. It asks: "What is the point of life?" and answers itself, "None."

But Zoo Story is outwardly the more appealing and more interesting play. Peter, "a richly comic person," a young man doing well in publishing, sits reading on a bench in Central Park, New York. Jerry, a "permanent transient," as he calls himself, insists on talking to him. Peter tries to brush him off, but he will not be brushed. First, he works on Peter's curiosity, then provokes him more and more, eventually by insults and blows—and they fight. Once Peter has been forced to come out from behind his possessions (symbolised by the bench they fight over) and his complacency, to confront the isolation and desperation of real life, to confront Jerry as a human being—Albee introduces an improbable and sentimentally theatrical ending. Jerry puts a knife in Peter's hand, and impales himself on it.

While Albee keeps to many of the conventions of an absurd play up to this point, all the assumptions of the traditional theatre burst in with Jerry's death. Meaning thuds back, and Jerry uses his dying breath to tell us what the play means. A terribly Mittel-European joke, I always think.

Alan Turner triumphed as Jerry—a splendidly sustained tour de force, in a part that is really an actor's dream. The accent was well held, the movements graceful—he used the area of the stage particularly well. The saga of Jerry and the Dawg (Malevolence with an erection) was truly memorable. Jim Lewis had a very much more difficult part, which he handled well. His command of it increased noticeably over the week. With very little dialogue or action, he very effectively communicated the character's tension and discomfort—his little uptight laugh was a pleasure. A confident production, it also drew blood most effectively.

III. Interestingly enough, the speech on the dying breath is just the theatrical convention that **A. P. Herbert** pillories in the splendidly gory ending of **TWO GENTLEMEN OF SOHO.** A much less interesting play intrinsically, this period piece formed a bizarre companion to the others—but was far more intriguing in this setting than it could ever be on its own.

*"A gesture, an event in the cosy little world of man is never absurd except relatively; in relation to the circumstances which accompany it. The words of a madman, for example, are only absurd in relation to the situation he's in, but not in relation to his madness."

A mild spoof of Shakespearean Theatre, it is written on about the level of a fairly accomplished undergraduate review item. A one-joke play, it does go on a bit too long for its own good, but it has some excellent lines. Very firmly set in a Thirty-ish period, it really seems rather prim in its depiction of the daring goings-on in a Soho nightclub. Saxophones seem to represent the last word in depravity in this chintzy den of cosy iniquity. The dancing partners, ladies and gentlemen of the demi-monde, work hard for their living—but it really seems to be sax rather than sex that they provide. How unlike our own dear Soho!

Its ending, though, is a sort of theatrical equivalent of Hoffnung's Symphony to end all symphonies. When the Duchess's indiscretions are finally made public, she dies the death—to be followed by the rest of the cast, leaving a heap of dead bodies that even Hamlet would have envied, while the detective makes the longest series of hilarious dying speeches on record.

Mark Turtle as Plum, or vice versa, died beautifully and at length; Cyndy Bach as Topsy and Sue Camplin as Lady Laetitia looked perfect period gems, and Simon Durnford made Lord Withers' ennui seem most natural. David Jones was a superbly captured waiter—the greasy hair and the glassy eye—we've met him many times before. Nick Bishop as Hubert, looked suitably exhausted as the victim of amatory excess. Mike Jones made such an effective sneak that he was hissed by the audience—a rare honour at Guy's! Marianne McLauchlan nearly conveyed the spirit of the Duchess of Canterbury, but she was not big enough. She should, if one may say so, have been stuffed more generously—for her figure resembled a deflating Queen Victoria, with most of the air let out. Andy Wozniak and David Jones produced and directed with some style—perhaps the piece could have had more panache had it been hammed a bit more enthusiastically. The musical accompaniment was well chosen, but the sound production didn't quite keep up with it each night.

So the Theatre Club continues its present crescendo—productions are getting better, bolder and more accomplished all year. One awaits the Christmas production with pleasure.

Michael A. Simpson.

NURSING SECTION

A New Look for Nursing

It has been interesting to note that the future of nursing has apparently been studied in some depth by those who direct the profession in this country. It seems that at last it has been realised that nursing is currently experiencing a rapid decline and something must be done to rectify the matter. The report submitted to the Briggs Committee, however, still leaves one in doubt about the establishment of nursing as a true profession.

The two most outstanding factors which leave cause for concern are the reduction of the age of entry, and the fact that it appears there will still be no standard educational requirements.

Firstly, the age of entry: It is appreciated that hospitals are liable to lose candidates to other careers if they cannot enter nursing until eighteen years of age. But are those who enter at seventeen going to manage to contend with what they find? It appears to have been proved by statistics—for what they are worth—that if for any career the standard of education is elevated, the number and quality of applicants also rises. Would this not also be true of age limits? In addition, with the public becoming increasingly anxious to sue the medical and nursing professions if the opportunity arises, is it morally right to employ these people before they are legally mature? In addition to this there is quite a marked difference in emotional maturity between the average seventeen- and eighteen-year-old. Is there then not a danger that the wastage rate could rise instead of fall?

Next there is the question of educational requirements. Should not this be levelled very much more? To obtain the title of nurse should mean one thing to people at large. At present anyone who puts on a cap and white overall can call themselves this. The title should mean that one has attained a definite level of education and obtained a certain qualification. In this way the profession as such could establish itself much more firmly.

It seems that the nurses in training will be treated as students in the future, and this presents one further cause for concern. Who is going to do the nursing? Has consideration been given to this and also to the problem of providing the trainees with sufficient practical experience? Although many nurses in this country are deeply concerned about the situation at present, most of them have no wish to find themselves in the type of predicament which prevails in the United States.

These then are some of the questions which require answers. Few would dispute the fact that the profession needs a complete overhaul. There is much wrong with it today. However, we do not wish to lose our standards, or ability to give the care which has always been considered the best. It is hoped that changes will be cautious and the implications carefully considered. Most of us do not want another Salmon farrago, but if care is not taken the outcome could be a situation worse than at present.

Haematology Multiple Choice

In the following questions one or more of the statements given is correct.

1. The heterophile antibody in glandular fever.
   A. Is usually detectable indefinitely after clinical recovery from the disease.
   B. Agglutinates sheep red cells.
   C. Agglutinates horse red cells.
   D. Is a gamma globulin of the IgM class.
   E. Is not adsorbed by guinea-pig kidney

2. The direct antiglobulin (Coombs) test is characteristically positive in
   A. Rh negative mothers who have formed anti-Rh antibodies.
   B Auto-immune haemolytic anaemia.
   C. Haemolytic disease of the newborn due to ABO incompatibility.
   D. Hereditary spherocytosis.
   E. Newborn babies with Rhesus haemolytic disease.

3. Inheritance is of autosomal dominant type in
   A. Haemolytic disease of the newborn.
   B. Haemophilia.
   C. Hereditary spherocytosis.
   D. Glucose-6 Phosphate dehydrogenase deficiency.
   E. von Willebrand's disease.

4. The spleen is usually palpably enlarged in
   A. Chronic myeloid leukaemia.
   B. Idiopathic thrombocytopenic purpura.
   C. Hereditary spherocytosis.
   D. Thalassaemia minor.
   E. Iron deficiency anaemia.

5. Febrile reactions associated with blood transfusions may be due to
   A. Red cell antibodies in the donor.
   B. Leucocyte antibodies in the recipient.
   C. Antibodies in the recipient to the transfused plasma proteins.
   D. Red cell antibodies in the recipient.
   E. Infected blood.

6. Iron-deficiency anaemia may result from
   A. A low fat diet.
   B. Idiopathic steatorrhoea.
   C. Tapeworm infestation.
   D. Ulcerative colitis.
   E. Gastrectomy.

7. Eosinophilia occurs in
   A. Malaria.
   B. Allergic asthma.
   C. *Polyarteritis nodosa.*
   D. Chronic myeloid leukaemia.
   E. Schistosomiasis.

8. Heparin therapy produces
   A. Fall in the platelet count.
   B. Lengthening of the prothrombin time.
   C. Lengthening of the Kaolin-cephalin time.
   D. Reduction of the fibrinogen concentration.
   E. Lengthening of the thrombin time.

9. A chemically abnormal haemoglobin is found in
   A. Hereditary spherocytosis.
   B. Sickle cell trait.
   C. β—thalassaemia major.
   D. Glucose-6-phosphate dehydrogenase deficiency.
   E. Some patients with congenital methaemoglobinaemia.

10. Hypoprothrombinaemia may result from
   A. Obstructive jaundice.
   B. Intestinal malabsorption.
   C. Liver failure.
   D. Disseminated intravascular coagulation.
   E. Overdosage with vitamin K.

11. A leuco-erythroblastic picture is characterised by
   A. Hypersegmented neutrophils.
   B. Immature granulocytes.
   C. High platelet count.
   D. Normoblasts.
   E. Polychromasia.

12. The neutrophil alkaline phosphatase is
   A. Raised in patients with a neutrophilia due to infection.
   B. Raised in polycythaemia rubra vera.
   C. Low in chronic myeloid luekaemia.
   D. Normal in secondary polycythaemia.
   E. Raised in myelofibrosis.

13. Red cell spherocytosis
   A. Can be detected on a blood film.
   B. Is seen only in hereditary spherocytosis.
   C. Is associated with a decrease in red cell osmotic fragility.
   D. Occurs in auto-immune haemolytic anaemias.
   E. Persists after splenectomy in hereditary spherocytosis.

14. An established risk of producing bone-marrow aplasia is associated with the therapeutic use of
   A. Digoxin.
   B. Phenylbutazone.
   C. Gold.
   D. Busulphan.
   E. Oxytetracycline.

The following sentences contain two statements of which either may be true or false. If both statements are true, they may or may not be related. Thus the answer may be given as True/False, False/False, True/True (related) or True/True (unrelated).

15. The ESR is raised in myelomatosis because the plasma calcium concentration is raised.

16. Megaloblastic anaemia occurs in pregnancy because dietary vitamin B_{12} deficiency is common in pregnancy.

17. Polycythaemia develops in some patients with renal tumours because some renal tumours produce erythropoietin.

18. Pernicious anaemia is commoner in women than in men because women are more prone to develop atrophic ileitis.

19. The serum iron concentration is low in iron-deficiency anaemia because the serum transferrin concentration is raised.

20. The serum vitamin B_{12} concentration is low in pernicious anaemia because the serum contains antibodies to gastric parietal cells.

Answers on page 412.

CORRESPONDENCE

Front Surgery

SIR,—I was interested to read the comments in Passim concerning Front Surgery. I assure you that there is no complacency regarding the teaching and training of dressers in Casualty at the present time, but improvement will not be possible until split appointments with other firms and specialties, not directly concerned in Casualty, are changed. It is a long time since it was originally suggested that the Orthopaedic and Casualty appointment should be combined because as far as I can see, this is the only manner in which a regular and more active student participation in the department can be achieved.

Yours sincerely,

W. A. CRABBE,

Surgeon in charge of the Accident Department.

Keats' House,
Guy's Hospital,
London, S.E.1.

SIR,—What a shame that the "duty" of being on surgical take-in should still involve the student in the "infuriating and educationally useless" activity of suturing in Front Surgery. I feel very sorry for him being dragged away from the consultant's round. Imagine the missed chance of an acute dilatation of the stomach, an Eisenmenger's syndrome—the mind boggles. He has to go and waste his time sewing up a cut.

To me, a country doctor, the practical experience gained in Front Surgery at Guy's has been of the highest possible value. I cannot remember being infuriated with this work; in fact, we rather enjoyed it.

Another point is that although some patients who arrive at Front Surgery could have been dealt with by their General Practitioner, they have chosen, or have been referred to, you.

Seize the opportunity to see them. After a while, you may realise that sewing up cuts and seeing non-urgent unglamorous "cases" is part of learning to be a doctor.

I am, etc.,

DAVID RHODES.

Woburn Sands,
Bletchley, Bucks.

SIR,—So now Casualty has become "infuriating and educationally useless". That you find it possible to write such words is a sorry fact and indicative of "something" being very rotten in the state of Guy's. I perform demonstrations frequently during the lunch hour and am increasingly finding that the number of students who attend is smaller and smaller and that the standard of students' case notes from the ward cases is getting poorer and poorer. What are the reasons for such poor attendance? Possibly I am a lousy teacher. If this is the case then I wish people would tell me and I will do my best to correct any faults. Possibly the students are at other lectures, etc. I doubt it. They seem to have no difficulty getting to my "more interesting" cases. Perhaps they are lazy. I doubt that they have changed much since my student days. Perhaps it is simply student apathy. A convenient phrase which enables us to put the blame on the students and dismiss it from our minds as something over which we have no control.

I however believe that it behoves us to look deeper into the causes of this apathy; after all, they were sufficiently motivated to get the necessary "O" and "A" levels and to struggle through 2nd M.B. so that they could finally walk

the wards. These surely are not signs of apathy. I have discussed the matter with many students and I think the sickness is graver than it appears on the surface. By their very junior nature they cannot be given a great deal of responsibility but have we not so stripped them of all function except possibly that of blood takers and general messengers that they are beginning to lose confidence in themselves? The official notes in my day were kept by the student and it was their duty to provide good continuation notes. These were consulted and used so that we felt that we were part of a team and that the recovery of patients was, in some small way at least, due to our labours. The present student is beginning to feel that he is a nuisance and that the hospital could be run much more smoothly if he were not there. I know it has been legally ruled that the notes must be kept by a registered practitioner but I believe this to be a grossly retrograde step. These things cannot be learned overnight and we must not forget that the uninterested student of today will be a poor houseman tomorrow and a rotten registrar the day after tomorrow.

We must get our students back into the team and to make them feel wanted. We must do this even if we have to get a High Court ruling that someone who has passed 2nd M.B. is a sufficiently responsible person to maintain proper case records. If this is not done then it will be the patients' loss in the long run. I am not suggesting that we shall get a miraculous cure overnight or that it will not be more work for the students but I fear that if we allow the present state to continue we will get to a point from which we may not be able to recover.

Yours faithfully,

COLIN HUNTER-CRAIG.

Department of Forensic Medicine,
Guy's Hospital,
London, S.E.1.

SIR,—I have read the Passim of 17th July concerning the work of Front Surgery. It may be of interest to some of your readers to know of the contrast between the behaviour of patients and the resulting work of the Accident and Emergency Department in Teaching Hospitals and in those outside the London area. Far from using the local Accident and Emergency Department for General Practice matters, most patients around here attend the G.P.'s surgery or call their own doctor for all sorts of major and minor accidents and emergencies in an attempt to avoid attending the Hospital, in spite of the fact that some of these conditions may be better dealt with there. Similarly there is a difference between the type of case frequently admitted to the Wards of Teaching and other London Hospitals compared to those in outlying areas.

This illustrates another facet of the problem of Teaching Hospitals, so many of which at present give students a poor idea of what both Hospital and General Practice is really like outside London. This is unfortunate enough for those who will enter General Practice, but they will soon be refreshingly enlightened. It is disastrous for the future consultants, many of whom never discover their misconceptions and are puzzled and hurt when they receive a rough ride at the hands of their G.P. colleagues. You will find that the consultants who most readily command the respect and friendly co-operation of the local G.P.'s are those who have themselves had personal experience in General Practice. Is there no hope of making a spell working in General Practice obligatory for all aspiring consultants?

Yours faithfully,

GILLIAN STRUBE.

The Surgery,
50 The Glade,
Furnace Green,
Crawley, Sussex.

The Music of Brückner

SIR,—Those who read G. L. Davies' excellent article on the Music of Brückner (17th July 1971), may be interested to hear more of the Viennese musical intrigue of that time.

Brahms' long success, and Brückner's difficulty in becoming established were by no means due only to their widely differing approaches to music. There was in the Vienna of the mid-nineteenth century a well-known music critic Edward Hanslick, who was very popular in polite society, but whose attitude to musicians could be summed up by his own comment "Whom I wish to destroy shall be destroyed".

This particular gentleman had far greater influence over which music the public went to, than our music critics today, and had taken up a personal crusade against Wagner and his music when that composer had become involved in the Dresden Rebellion of 1848.

Brückner's music was associated by Hanslick with Wagnerism, especially as Brückner openly stated his admiration for Wagner, and wrote for Wagner Tubas (a cross between a Tuba and French Horn), some of his symphonies. Brückner was for these reasons considered very "anti-establishment" whereas Brahms suffered from no such shortcomings!

Yours faithfully,

IAN STARKE.

East Wing,
Guy's Hospital.

Follies Thamesmead

SIR,—Your readers will by now be familiar with the incidence of Hand, Foot and Mouth disease at Thamesmead (Guy's Hospital *Gazette* 27th February 1971). May I ask, Sir, through your columns, whether they are also aware of symptoms of a more alarming nature which are currently presenting there?

In a recent sample, more than a dozen examples of a virulent new strain "Carnivalitis Urbanus" were encountered among otherwise sane, normal members of the community. Symptoms include bursts of activity, literary rushes, telephonic hysteria, and throughout, chronic apprehension concerning the future.

Clearly, local staff are unable to deal with this outbreak of epidemic proportions, and I am appealing to your readers to volunteer, as half a dozen brawny students will be needed when this disease reaches fever pitch at the Thamesmead Town Show on Monday, 30th August.

If such volunteers could be found, their main role would be to organise some stunt or activity (wrestling in mud, mock appendectomies?) which would draw attention to the links between Guy's Hospital and Thamesmead.

Anyone feeling brave should contact Patrick Forbes, 4 Coralline Walk, Thamesmead SE2 9SU (phone 310 3860) who will make arrangements for the necessary immunisation.

Yours sincerely,

PATRICK FORBES.

4 Coralline Walk,
Thamesmead,
London, SE2 9SU

Swallow This

SIR,—I must apologise for occupying more of your valuable column space, but a matter has come to my attention which I feel should be brought into the public eye. It concerns the student's bar in the East Wing. Several months ago it was decided to open the bar at lunch-time, to serve in addition to the usual liquid refreshment, sandwiches and pies, etc. So successful was this scheme that lunchtime attendance at the Spit dropped to the horde of mice and cockroaches fighting over the cornflake crumbs left over from breakfast.

However, about two months ago, lunch-time opening of the bar was abruptly stopped with no accompanying explanation, and thus the situation has remained. Rumours have since been circulating that there is a financial crisis in the bar the like of which the world of international high finance only contemplates with a shudder, and compared with which the Rolls-Royce collapse assumes the importance of a crack in a child's piggy bank. The other possible explanation which immediately sprang to everyone's mind's is that lunch-time opening was stopped as a underhand method of eliminating competition for the Spit, in which case the matter should immediately be reported to the Monopolies Commission.

The question I ask as representative of the people is this—Why have we not been informed of the reasons for closing the bar? Have the centuries-old democratic tradition of this great hospital of ours been submerged by the tidal wave of totalitarianism? Is this a plot by the capitalist imperialist bourgeois paper tigers to destroy the morale of the student revolutionaries? It is in the mire of such injustices that the seeds of revolution flourish.

Yours revolutionarily,

ARNOLD SCHULTZBERGER

Guy's Hospital,
London, S.E.1.

"More Time Gentlemen Please"

Did you know that the bar in the club we all share
Was once closed for its lunch-time sales?
And the reason they give us, an answer quite rare,
That they lost on the price of their ales.

It's a shame don't you know that the bar is still closed
Through the lunch-hour when everyone's dry
And if you should ask, the same story is posed
It just doesn't pay us, they cry.

If the "Lord at the Grapes" we all know in the "High";
Found the profits he made were too low
His patrons surely would never go dry
To boost lunch-time sales; don't you know?

Where are the voices of Guy's Noble Halls?
Sing out to change this bold farce
God damn the man who says no to our calls
For the little request of a glass.

N.S.M.

SPORT

CRICKET

MATCH v. MOTE

Saturday 26th June. Away. Lost by 8 wickets

Having a potentially strong batting side Guy's elected to bat. Winter, having returned from a lack of cricket in the States, and Langdon opened the innings. Winter looked a bit unhappy against the pace of Sayer, who still plays a reasonable amount of county cricket, but Langdon played quite well and they took the score to 30. However, Langdon tried to hook Sayer twice in succession (not a good idea) and lobbed up an easy return catch and then wickets began to tumble.

Winter was bowled, and Holland and Goodhart followed in quick succession each for a round number. Powell-Jackson got stuck in but apart from Croft none of the other batsmen made a significant contribution (except perhaps the visual delights of a Hanson innings!) and we were all out at lunch for 82 with Powell-Jackson 23 not out.

After lunch the Mote knocked off the runs for 3 wickets (that speedy opening bowler Davoodbhoy took 2 for 31) and we then played an overs match.

Mote set us 155 in 35 overs but once again we couldn't make it and failed by 30 runs. However, it was an enjoyable, if not successful day's cricket.

MATCH v. SOUTHGATE

at H.O.P. 3rd July. Result Draw.

Southgate batted first and their opening pair put on 37 before Goodhart bowled the dominant partner. From then on the bowling was dominated by Gillham. He bowled a marathon spell of 23.3 overs to obtain the stunning figures of 9 for 41. This was a revelation to most of the side who must wonder why this demon bowler has been kept in the background for so long. However, the general opinion of Gillham's performance was lessened when he failed to buy the customary beer. Southgate were struggling at 125 for 9 when a last wicket stand put on 32 to bring their final total to 155.

When Guy's batted, Fitton produced an amazing array of shots but was out for 24. Langdon and Evans batted well and provided most of the Guy's runs with 31 and 27 respectively. However Guy's then lost some wickets whilst going for quick runs and it was left to Goodhart to play out the final overs for a draw with the total at 119 for 8.

Team: R. Goodhart, C. Langdon, G. Evans, R. Fitton, J. Rees, E. Hemming, A. Holland, A. Gillham, D. Young, S. O'Keefe, M. Harris.

MATCH v. MADHATTERS

at H.O.P. 4th July. Won.

The match was started rather late and a team of eight Madhatters batted first. They crawled slowly to 123 runs helped by some very poor Guy's fielding. Gillham failed to live up to his promise of the day and took only one wicket in ten overs. Harris and O'Keefe took 3 wickets each.

Guy's started badly losing Fitton and Gillham with only 13 runs on the board. Then a good stand of 55 between Goodhart and Evans helped the score along. Evans was then out for 28 being stumped while playing a shot which bore a great similarity to that he played the day before. Clifford-Jones was out quickly but Rees and Goodhart scored the runs needed for Guy's to win a match which they never really looked like losing. Goodhart scored a fine 53 not out and Rees 21 not out.

Team: R. Goodhart, R. Fitton, A. Gillham, G. Evans, R. Clifford-Jones, J. Rees, E. Hemming, D. Young, S. O'Keefe, M. Harris.

J. REES.

HOSPITAL INFORMATION

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited from medically qualified graduates for appointment from 1st October for one year in the first instance as **Research Assistant** in the Department of Surgery to work in the breast unit on a research grant. The post will provide opportunities for clinical work and is suitable for someone working for a higher qualification. Salary according to experience in the Senior House Officer-Registrar range. Further details and form of application obtainable from the Dean, Guy's Hospital Medical School, London Bridge, S.E.1.

GUY'S HOSPITAL AND SOUTH EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited to fill an established vacancy for the appointment of **Senior Registrar** in Rheumatology to the Guy's Board of Governors and the South East Metropolitan Regional Hospital Board to commence on 1st October, 1971. The successful candidate will work seven sessions a week at Guy's and four sessions a week in either the Cray Valley and Sevenoaks Group or the Greenwich District Group. The appointment will be made jointly by the bodies concerned. The responsibilities will include care of in-patients and out-patients and teaching at undergraduate and post-graduate levels. Three sessions a week will be devoted to research and laboratory facilities are available. Forms of application are obtainable from and should be returned to The Superintendent, Guy's Hospital, London S.E.1, not later than **13th August, 1971.**

THE NEUROSURGICAL UNIT OF GUY'S, MAUDSLEY, AND KING'S COLLEGE HOSPITALS

De Crespigny Park, London, S.E.5.

Applications are invited for the post of **Research Associate in Paediatrics** for one year only to investigate various aspects of epilepsy in childhood. The post will carry the status of a senior registrar, and the applicant will work in the Neurosurgical Unit with attachments to the Paediatric Departments of Guy's and King's College Hospitals. A higher qualification in medicine and previous experience in paediatrics are essential. Some experience in neurology would be an advantage, but is not necessary. Further particulars and application forms are obtainable from the Dean, Guy's Hospital Medical School, London Bridge, SE1 9RT. Closing date **26th August, 1971.**

THE BOARD OF GOVERNORS OF GUY'S HOSPITAL invite applications for the appointment of a **Consultant Clinical Microbiologist** (maximum part time or whole time). The successful applicant will be responsible to the Professor of Microbiology in Guy's Hospital Medical School for the service commitments of the hospital. Further information may be obtained by telephoning Dr. J. Liddell (01-407 7600 ext. 250). Detailed applications together with the names of three referees should be forwarded to The Superintendent, Guy's Hospital, London S.E.1, not later than **20th August 1971.**

THE BOARD OF GOVERNORS OF GUY'S HOSPITAL invite applications for the appointment of **Consultant Paediatrician** (maximum part time or whole time). The successful applicant will work five sessions as Consultant Paediatrician in the National Health Service at Guy's and the remainder of the period as Senior Lecturer in Paediatrics in Guy's Medical School. The duties will include clinical work, research and teaching. In addition to training in Paediatrics, special training in and experience of paediatric nephrology is essential.

Detailed applications together with the names of three referees should be forwarded to The Superintendent, Guy's Hospital, London, S.E.1, not later than **20th August 1971.**

PERSONAL

CLAPHAM PARK—Well furnished flat, one bedroom, drawing-room, dining room-cum-spare bedroom, kitchen and bathroom. Available October for one year. £12 per week. Tel: 675 1587.

WEEK-END RETREAT — Fully furnished equipped s/c 2 bedroom flat near Eastbourne; wonderful views Sussex downlands. For long let. Box No. 5/7.

Ann Porter (Casualty) and Chris G. Rowland (Residents' Bar) would like to congratulate Dr. and Mrs. C. J. Rowland, of Surbiton, on the birth of their twin daughters.

BIRTHS

GUERRIER—In Torquay on 17th July, to Jennifer (née Turner) and Dr. Tim Guerrier, a daughter (Sophie Helen) sister for Jamie.

MOWBRAY—On 21st June, 1971, to Howard and Carolyn, a son (Matthew Guy Howard) a brother for Theresa and Aidan. Present address: Charles Johnson Memorial Hospital, Nqutu, Zululand via Dundee, S. Africa.

CHANGES OF ADDRESS

Mr. R. A. V. Lewys Lloyd, 21, Kinnaird Avenue, Bromley, BR1 4H9.

Mr. Howell Richards, 4, Upper Wimpole Street, London, W1M 7TD.

Dr. John A. Mathews, "Midhurst", 6, Longwood Drive, Roehampton, London, SW15 5DL, and at 102, Harley Street, London, W1N 1AF. Tel: 01-935 2414.

DEATH

GREEN—In May, 1971, in the Yugoslavian air disaster, Roger and Anne (née Wicks) and their children, Ian and Simon.

PAPERS BY GUY'S MEN

Cremin, B. J. and another. Striation (longitudinal mucosal folds) in the upper urinary tract. II—A comparison of findings in children and adults. *British Journal of Radiology*, 1971, **44**, 449.

Evans, P. R. Sotos' syndrome (cerebral gigantism) with peripheral dysostosis. *Archives of Disease in Childhood*, 1971, **46**, 199.

Forgacs, P., Nathoo, A. R. and another. Breath sounds. *Thorax*, 1971, **26**, 288.

Fry, J. Primary medical care in Africa. *Journal of the Royal College of General Practitioners*, 1971, **21**, 356.

Grahame, R. and another. Rheumatology. In *Medical Progress*, ed. Sir John Richardson. Butterworth, London, 1971.

Kerr, I. H. Comparison of Streptokinase and heparin in treatment of isolated acute massive pulmonary embolism. *British Medical Journal*, 1971, **2**, 681.

Lehner, T. Lignocaine hypersensitivity. *Lancet*, 1971, **2**, 1245.

Mackeith, R. C. Price of treatment. *British Medical Journal*, 1971, **2**, 655.

Rake, M. O. and others. Controlled trial of Phethabarbital, a non-hypnotic barbiturate, in unconjugated hyperbilirubinaemia. *British Medical Journal*, 1971, **2**, 497.

Reader, N. L. M. An ancient practice alive and well today: the story of Westgate End House. *Practitioner*, 1971, **206**, 691.

Reeves, W. G., Cameron, J. S. and Ogg, C. S. IgE and the nephrotic syndrome. *Lancet*, 1971, **1**, 1299.

Ross, D. N. and others. Viability of autologous fascia lata in heart valve replacements. *Thorax*, 1971, **26**, 277.

Turk, J. L. Hypersensitivity. *Scottish Medical Journal*, 1971, **16**, 273.

Weller, R. O. and McArdle, B. Calcification within muscle fibres in the periodic paralyses. *Brain*, 1971, **94**, 263.

Michael A. Simpson. Leonardo da Vinci—Anatomist. *New Doctor*, No. 18, Feb.-Mar., 1971, pp. 12-14

Michael A. Simpson. "Sadan kan det ogsa siges . . ." *Stud. Med.* Copenhagen, August 1967, Vol. 31, No. 6, p. 146.

Michael A. Simpson. Surgeons and Technical Skill. *British Medical Journal*, 26th June, 1971, **2**, 775-776.

Haematology Multiple Choice Answers

1. BCDE
2. BE
3. CE
4. AC
5. ABCDE
6. BDE
7. BCDE
8. BCE
9. BE
10. ABCD
11. BDE
12. ABCDE
13. ADE
14. BCD
15. True/True, unrelated
16. True/False
17. True/True, related
18. True/False
19. True/True, unrelated.
20. True/True, unrelated.

Dr. P. Barkhan, in the Department of Haematology, would welcome any criticism of this multiple choice, which he compiled.

GUY'S HOSPITAL GAZETTE

EDITORS N. D. S. BAX and A. M. TURNER
NEWS EDITORS R. M. DARLING and J. L. LEWIS
SPORTS CORRESPONDENT A. M. ROYSTON
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TEN PENCE VOLUME 85 NUMBER 2168

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Generally over the past year the quality of teaching at Guy's has improved. The initially non-constructive ideas on teaching are now becoming increasingly tempered with sense. This combined with the fact that there are some teachers at Guy's who are interested in teaching, and some, but not to the exclusion of the former, who are very good teachers, has helped to raise teaching standards. The time when the maxim, "if it was good enough for us, it is good enough for them", held good, if it ever did, has now been passed. Simply, it is no longer true.

It would be reasonable to hope that the modes of imparting the relevant and increasingly voluminous medical material change as rapidly as everyone's desire that medical schools should produce increasingly better doctors. The excellent example in experimentation in medical education that is taking place in pre-clinical years has proven its worth. Until very recently a new clinical student would have been disappointed at the sparsity of innovation on the wards, in clinical lectures, and so on. However, the enthusiasm and wisdom of an ever increasing few is having an important and essential effect.

Visiting students not always out of politeness often say how fortunate we are at Guy's as regards our teaching. Of late we have more reason to feel happier. One can but hope that the inevitable complacency that has in the past enshrouded such a situation as we now have, will not descend. Possibly never before at Guy's has there been the very necessary sympathy between the teacher and the taught, and it is in this that lies one of the great potential strengths of our hospital. We are beginning to become most fortunate.

A Dog's Obeyed in Office

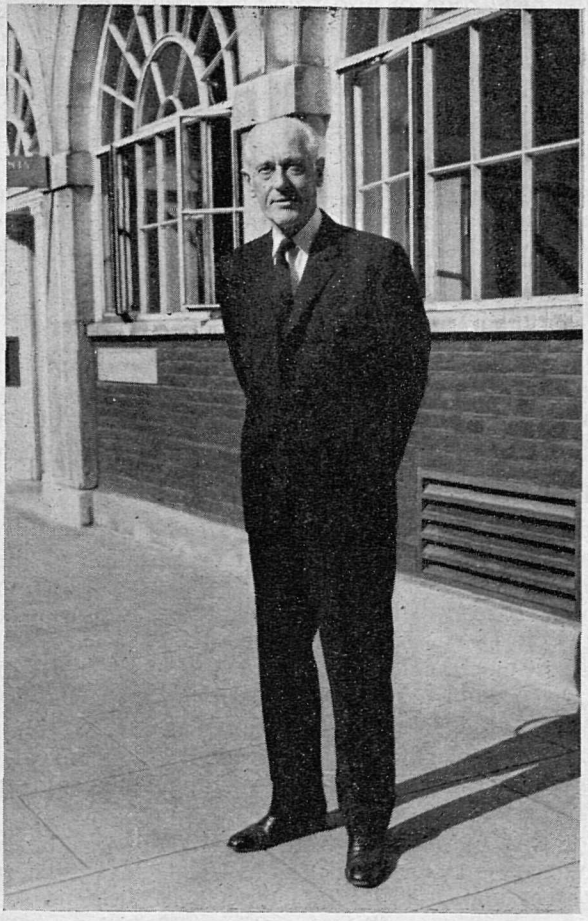
What defines corruption? When is a piece of writing or a cartoon obscene? The recent trial of the editors of Oz 28 served as a touchstone for the views of the so-called cultured and counter-cultured. The proponents of the counter-culture, an historically naïve term that exhibits a curious ignorance of the evolution of cultures until now, claim that they represent the way of the future, of the young who have not as yet strangled themselves into the stertorous grunts of the uncommunicative, strait-jacketed society that spawned them. They claim a new kind of freedom, a personal morality which continually refers to itself and not to history for authority. By locking up their spokesmen and trying to seal off the storm, it is predicted that the established only weighten the waves that are needed to, and inevitably will, overcome their protective walls.

The jury decided that what was shocking was also obscene and the judge decided that people who shocked them had lost their right to our trust and should therefore be removed, temporarily, from free intercourse with society. Now that view readily attracts many supporters. Many films recently have seemingly deliberately engaged the emotions of the spectator into sympathy with a character or group, and then that figure of audience identification has been dealt with callously and violently in the most gory spectacular way. The natural emotion is to feel that such brutality is unnecessarily sickening, cruel and, finally, improper. The artist has betrayed his trust. But should he be imprisoned for it? Should he even be censured for it in any way other than that people should refuse to see the films or read the plays or magazines?

William Shakespeare should perhaps have been locked up for putting out the charming Gloucester's eyes and then having Lear explain to him that he was as much at fault as anyone else for being a member of a nasty species in which such atrocities inevitably occur. That is shocking and could be construed as a manoeuvre to make violence more acceptable. There is perhaps the point that Shakespeare wrote well and the obscenity of the 28th edition of Oz was that it was written appallingly badly. In that case we should lock up the authors of many modern pieces for being better shockers.

The law is taking a paternalistic rôle. It should recognise that in literary matters it does not occupy the position of father.

NEWS IN BRIEF



Ralph Kauntze Retires

The end of July, 1971, saw the retirement of Dr. Ralph Kauntze, Physician to Guy's Hospital since May, 1948. Dr. Kauntze was educated at Canford School and Emmanuel College, Cambridge, and he received his clinical training at St. George's Hospital, London, where he was a William Brown Senior Scholar. In 1935 he received Conjoint qualifications and two years later he graduated M.A., M.B., B.Ch., from Cambridge. In 1939 he attained M.R.C.P. and started his service in the Royal Army Medical Corps. He served chiefly in the Mediterranean area and achieved the rank of Lieutenant-Colonel. He received the M.B.E. in 1944 and returned to civilian life in 1945. For two years he was the Assistant to the Director of the Department

of Medicine at Guy's. In 1948 he became an Assistant Physician, joining the staff at the same time as Mr. T. L. T. Lewis, and in 1956 he became Physician to the Cardiac Department. Dr. Kauntze also has the distinction of also being a Consultant Physician to the Royal Masonic Hospital and an Honorary Visiting Physician to Johns Hopkins Hospital, Baltimore, Maryland. He was elected F.R.C.P. in 1950. Dr. Kauntze's early retirement brings a premature end to a very distinguished career.

New Consultants

Douglas Pickering, M.B., M.R.C.P., D.C.H., who qualified at Guy's and who was a founder-member of the Spirochaetes, was recently appointed Consultant Paediatrician with a special interest in cardiology to the Radcliffe Infirmary, Oxford, and to the United Oxford Hospitals.

Graham Snodgrass, M.B., Ch.B., M.R.C.P., D.C.H., has been appointed Consultant Paediatrician to the London Hospital. Although he qualified in Edinburgh, he has become well known at Guy's during his $3\frac{1}{2}$ years as Assistant Director of the Department of Paediatrics.

Both are to be congratulated on their new appointments.

New Medical Firms at Guy's

The departure of Professor Butterfield and the recent retirement of Dr. Kauntze have necessitated the reorganisation of the medical firms at Guy's. From 1st September, 1971, there will be four medical firms at Guy's instead of the present five. The firms will be: (1) Dr. Mann, Dr. Scott, Dr. Clark, Dr. Grahame; (2) Dr. Hardwick, Professor Trounce, Dr. Cameron, Dr. Ogg; (3) Dr. Houston, Dr. Knight, Dr. Deuchar, Dr. Grimble; and (4) Professor Lessof, Dr. Joiner, Dr. Burry, Dr. Sowton.

The reduction in number of General Physicians at Guy's is because of the increase in consultant appointments in specialised fields.

As a result, by 1st December, 1971, there will be two fewer House Physicians and one Registrar fewer at Guy's than at present. The number of junior staff within the Guy's Group will, however, remain the same. There will be four House Physicians at New Cross instead of the present two and one Registrar from Guy's will transfer to St. Olave's. New take-in arrangements come into effect on 1st September. Each firm will be responsible for take-in on one day only between Monday and Thursday. The firm responsible for the Monday take-in will also do the following week-end (Friday, Saturday, and Sunday).

To add to the confusion there is the problem of student firms. At present there are four student firms at Guy's, but five medical firms. This means that one student firm is doing the work of two. However, by the time the next firm starts on 1st October, 1971, most of the staff changes will have been completed and there will be a return to normality.

Southwark Cathedral and Bridge as seen from the Tower.

Physiotherapy in Preventive Medicine

by

Marguerite E. Pennefather, M.B., Ch.B., D.(Obst).R.C.O.G., M.R.C.P.

Elizabeth R. Tanner, M.C.S.P.

We should like to take this opportunity of expressing our thanks to the Department of General Practice, and in particular to Professor Butterfield, Dr. Robert Smith, and Dr. Peter Higgins for their encouragement and help in the early stages of this study; without this kindly interest it could never have survived.

The accepted image of physiotherapy, apart from a few recent innovations such as pre-operative breathing and ante-natal exercises, is a form of treatment which takes place after, often long after, a medical or surgical condition is well-established. "It doesn't seem to be clearing up even now, does it? Perhaps we had better see what some physiotherapy will do." This attitude is, of course, bound up with the fact that, at present, physiotherapy is only available in hospital, unless some private arrangement can be made, and hospital attendance may entail expenditure of time, transport by 'bus or ambulance, and in some cases considerable fatigue.

Both of us have had experience with the geriatric age-group, from a social as well as a medical angle, and are interested in the contribution made by physical disabilities to the break-up of domestic life, whether the old person is living with spouse, children, siblings, or alone, and we are of the opinion that early physiotherapy could offer much in preventing the development of disabling musculo-skeletal handicap. It was decided to approach the matter from a practical angle, and in June, 1966, a weekly physiotherapy clinic was started in the group-practice. (Pennefather and Tanner. 1968.)

In giving some account of this Study it is convenient to use the headings of Leavell and Clark from "Preventive Medicine for the Doctor and his Community" (1938).

Primary Prevention

1. Health Promotion.
2. Specific Protection.

Secondary Prevention

1. Early Diagnosis.
2. Prompt Treatment.

Tertiary Prevention

1. Disability Limitation.
2. Rehabilitation.

Primary Prevention

1. Health Promotion

Any "family tendency" to chest complaints is considered; the mother is asked to take baby to the physiotherapy clinic where she will be taught simple procedures to keep the child's chest clear of mucus, particularly during the winter months. To "tip" a small baby effectually is rather a terrifying experience for a young mum, and time and patience are needed to ensure that she uses the proper grasp, and really tips him so that the level of his head is well below that of his seat. Unless this is done, she will lay the baby flat on her lap, regardless of the laws of gravity. With older children in the 0—4 age-group, the mother and child are both shown games to clear mucus and encourage good thoracic excursion.

Ante-natal exercises are of course included in this section, as not all mothers are willing to make the journey to hospital for the special physiotherapy classes. This contact with the young pregnant woman gives the physiotherapist an opportunity to check on any minor foot or postural disorders which might be looked upon as "normal" by the patient herself.

2. Specific Protection

This can be offered to patients of all ages whose work entails muscular effort. Malalignment in inanimate objects is viewed with considerable apprehension as to the effects on the efficiency and life of a machine; some of us spend a high proportion of our leisure time in adjusting minimal "deviations from the true" in cars, household appliances, etc., knowing that errors in transmission of weight or force will result in the premature wearing-out of moving parts, and interference with performance. Moreover, not only will the parts directly affected be concerned, but the whole machine will gradually deteriorate. Malalignments are usually less well appreciated in human beings until they reach a fairly advanced stage; the patient grows accustomed to poor performance of a limb, and the attention of the doctor is often being directed to ears, cough or constipation.

Post-natal exercises are an aspect of specific protection, and particularly those for the abdominal muscles and the levator ani. Urinary incontinence is one of the most common disabilities in old people, and, in women, the history often dates from childbirth.

Secondary Prevention

1. Early Diagnosis

This is essentially the responsibility of the doctor, but he may elect to delegate the detailed examination of muscle function to the physiotherapist, whose training has developed a fine appreciation of minimal deviation from the normal in this field. Ideally, a "physical check" should be carried out by her on all new patients registering with the practice, and on every patient reaching the age of forty. Often, patients are unaware of minor failures in musculuar performance, or consider them too trifling to bother a busy doctor; the result is that the early stage, when correction would be valuable, passes un-

noticed into the stage where "my bad back" or "my bad leg" comes to dominate the patient's life, becoming in some cases a cherished personal possession from which he will not willingly be parted.

2. Prompt Treatment

Sending a patient to a hospital department presents considerable obstacles where the condition is not one of urgency. The patient is often unwilling to go when this entails time off from work, expense, or getting someone to mind the children, and is further discouraged by the widespread idea that it will mean "endless waiting about". The doctor is doubtful about using consultant time on what is at present a minor complaint, so that re-education is postponed in the pious hope that "it will get better on its own". This, of course, may occur, but only too often, the patient is left with an increasing muscle imbalance which is likely to present real disability in later life.

Tertiary Prevention

1. Limitation of Disability

"Your patient, Mrs. Dash, was discharged from ——— Ward yesterday; you will receive the detailed assessment of the progress of her condition, Multiple Sclerosis, in a few days. An ambulance will call to take her to the Physical Medicine Department on Monday at 9.30 a.m."

Mrs. Dash is 46 and lives on the third floor of a block of flats without any lift. Even if more urgent commitments do not make the ambulance late, the whole procedure is very exhausting for the patient, and it is possible that Mrs. Dash will be too tired to remember what she has been taught in the physiotherapy department. It may be better for the physiotherapist attached to the general practice to accompany her to see the consultant in physical medicine and carry out her treatment at home. Few visits will be needed if Mrs. Dash's activities are related to her home surroundings, and the physiotherapist, during these visits, makes a note of any signs of remission/deterioration, encourages the family to give effective, but not officious help where needed, and co-operates with the Welfare Department in the siting of grab-rails, special lavatory seats, etc.

2. Rehabilitation

"Mr. Blank's walking plaster has been removed today and he has been given an appointment in Physiotherapy for 10 a.m. on Thursday. . . ." And very proper, too. Unfortunately, Mr. Blank, who is sixty-seven, feels disinclined for the bus journey that lies between him and the hospital; queueing in the rain, being jostled as he gets in, or the bus setting off with a jerk whilst he is still on the platform, do not appeal to him. So, he takes up his father's stick, which is several inches too short for him, and makes shift as best he may to "get about"; developing strains in his back, hip and knee. He would have been able to come up to the G.P's. surgery, taking his time, and could have been taught to use his now unfamiliar, plasterless leg to the best advantage.

This is true of younger patients who "can't spare the time to go up to hospital", and develop gaits that serve them poorly as the years go on.

Another form of rehabilitation, often unconsidered, is the re-education of the pelvic floor muscles where control of micturition is inadequate. It has been referred to earlier in this paper under the heading of "Specific Protection", but, although in many cases it can be connected with perinatal occurences, it may also arise after pelvic surgery, and sometimes due to inadequate thoracic excursion. This last condition surprised us very much at first, but it seems reasonable to suppose that full thoracic excursion with a firm abdominal wall will evoke a stretch reflex in the pelvic diaphragm if the latter is capable of response; we have a number of patients for whom such re-education has been very satisfactory.

We have learned a great deal about the role of physiotherapy in Preventive Medicine during the past four-and-a-half years and realise that there are great possibilities still unexplored. With the geriatric load steadily increasing it becomes essential that all available weapons shall be used in the struggle against preventable disability.

Reference

Pennefather, M. E. and Tanner, E. R., *The Practitioner*, December, 1968.

NOTICE

GUY'S HOSPITAL PHYSIOTHERAPY AUTUMN BALL

Friday, 24th September, 1971

Dinner Dance at the Hurlingham Club.

Double Ticket, £5.25.

Apply—Miss A. E. Clooney or Miss J. Osmond,
School of Physiotherapy, Guy's Hospital.

Singular Effusions

". . . little can be expected from the endless acquisition of data which continues to confirm what we no longer fail to expect."

J. H. Edwards: The Nature of Genetical Disease.
("Lancet", 22nd May, 1971).

Brilliant, Professor Edwards. Possibly you were not addressing us, but you may have been.

Coulter, S. has been at Guy's for well over a year now and we may perhaps take this opportunity to consider what progress has been made, whilst in fact dealing with something entirely different. Although not a Guy's man, S. Coulter made his way up four flights of stairs unassisted, to the top of Hunt's House, where he managed to survive without going nuts. It occasionally happens as a matter of fact. The father was not a Guy's man either—not even dental.

But seriously though, the Coulter, S. changes blood into numbers which are ejaculated on to flimsy pink sheets. For those who really know their haematology, and one or two names spring to mind, the final jerk on the print-out, the MCHC, may have provided some surprises in providing none. According to the year's MCHCs no cases of iron deficiency have been seen at Guy's over that period. Thus those who know what the MCHC means, don't know (*British Journal of Haematology*, 1972) and those who don't know, should know, are damned stupid but cannot possibly know. In point of fact the MCHC means something else. It is as simple as that.

Now comes the really clever bit: the result sheets are stuck sideways on to the request cards, thereby obscuring any information which an enquiring individual might wish to co-ordinate. A comment is then written upside-down and from right to left by someone who thinks that he is earning a living. This is the substance of the Coulter Counter Counter Culture, which works on the belief that if your brain is giving you trouble then rules can be a lot of help. Not my rules or your rules but someone else's rules. Dr. Big's rules. Now Dr. Big's rules are getting to be a problem.

The second part of this lecture is concerned with the serum iron, PBI or cerebral arteriography or something else. Of course, it is high or low or normal. That is why we measured it, Professor Edwards; after all, we have the methods and the machinery for measuring all sorts of rubbish, so why not use them? Whilst we are all using them, and that means everyone, "the service is oversubscribed and in danger of breaking down. . . ." An application is being made for a hundred grand for a new, better machine which will do anything anyone can dream of. However, one problem has not yet been overcome, that is when the machine is idle it starts to eat people. This is the only really serious sentence on this page. (Which one?)

If the results submitted by the machine are not entirely what

we expected, we will gladly refund you the cost of a new packet, dismiss the whole thing as absurd and forget it. Alternatively, we have a non-problem on our hands to investigate but neither the time nor courage to argue that it is a waste of both. Correspondingly we embark on a sequence in which we can waste not only our own time, but also the time of such unimportant people as patients, nurses and technicians, on the grounds that they are all paid to do as they are told, except for the patient, who is lucky not to be paying and who is in any case told nothing at all.

Spike Milligan anticipated Professor Edwards with his catch-phrase: "I don't wish to know that fact." What a shame that the catch-phrase got away.

MSR.

BOOK REVIEWS

THE NEW GENERAL PRACTICE: 2

British Medical Association, 1970, £1.25.

In recent years, general practice in Britain has been going through a revolution which is continuing to alter and transform the familiar pattern of traditional family medicine. A series of articles originally appearing separately in the *British Medical Journal,* has been collected together and published, very cheaply, as the second volume of a series on general practice. The contributors come not only from inside general practice, but also from public health, hospital medicine, administrative medicine and from other professions.

Probably the most significant change in practice is the family doctor's increasing awareness that his patients' welfare depends on many factors in addition to their physical health. He is now willing to share the care of his patients with others, and from this has sprung the idea of "the team". Nine of the 27 articles in the book discuss various ways in which midwives, nurses, health visitors and social workers can be freed from their past isolation and brought into their proper place as members of a team of specialists in community medicine.

There are sections on the relation between general practice and hospitals; the use of computers; improved methods of record-keeping to facilitate family care and research into community health; screening programmes for selected groups; the pattern of medical care in new towns; and a glimpse of general practice in Scandinavia.

The picture of general practice which emerges is of an area of exciting new development and possibilities. The contributors are enterprising and enthusiastic. Their differing approach and outlook stress the variety of conditions and organisation in practices in this country. Those already within general practice will find much to interest and stimulate them, while those contemplating it as a career or working in other fields of medicine may be surprised to discover how much old ideas are changing.

Finally, the contributors show that the traditional relationship between doctor and patient need not suffer from alteration in methods and practice organisation, but should benefit from them. If a third volume is added to this series in another two years' time, it will be fascinating to see how much further along the road general practice has travelled.

R.M.T.

ELEMENTS OF MEDICAL GENETICS.

Alan E. H. Emery. E. & S. Livingstone, 2nd edition, 1971.

This book is intended primarily for medical students but will certainly be useful to medical graduates, nurses, midwives, health visitors and social workers.

It is well written with clear explanations and diagrams. Each chapter outlines the history of its subject with text references to all the major workers in the field and takes the reader fully up-to-date with recent work. Unfortunately the work referred to in the text is not cited as full references and this may prove difficult for students wishing to look at the original work.

Particularly useful, however, is a list of suggested further reading at the end of each chapter. At the end of the book there is a useful glossary.

In the chapter on chromosomes the diagrammatic karyotypes are of poor quality and the technique described is somewhat dated.

There is an excellent chapter on genetics and the physician. On the whole a very useful book published in paperback at a reasonable price of £1.25.

SURGEON IN NEPAL, by Peter Pitt. John Murray. £2.50. 225 pp.

From 1966-68, Peter Pitt was surgeon at the British Military Hospital in Dharan, where the flat terrain of Eastern Nepal meets the Himalayan foothills. This hospital is possibly the best in the whole country and its good name is well known throughout Nepal among both doctors and inhabitants, who may walk for days to reach it. The hospital was opened in 1960 to safeguard the health of the British and the Gurkha soldiers and their families who were working in the cantonment that was built as a recruiting depot for Gurkha soldiers joining the British Army. It also serves as a centre for paying the pensioners and resettling the Gurkha soldiers to life in the hills on completion of their service in the Army.

A visitor to Nepal could never write a book about it without describing some of the fascinating customs to be found there. Peter Pitt is no exception, and although he, in fact, never had time to experience the foothills for himself his descriptions are both accurate and entertaining. He deals with the Nepalese passion for both smoking "bidis" and drinking "Raksi", and the conditions which follow in their wake, namely, Buerger's disease and hepatic cirrhosis.

Dharan is surrounded by tropical forest in which many wild animals freely live. Peter Pitt describes the blood-curdling and nauseating injuries so frequently inflicted by snake, leopard, tiger and bear and the life-saving surgery he ably provided. The section of the book dealing with cholera, gas gangrene, rabies, osteomyelitis and goitre was for me the most interesting from the medical point of view. His description of a rabid dog is particularly memorable. "The tail . . . hangs down like a plumb-line, for there is no tone left in the muscles of the tail. The dog's eyes are red, the tongue protrudes and saliva is frothing from the mouth. The poor dog, though a menace to all, is itself in agony, not even able to swallow its saliva. The dog snaps at anything and everything in its path, often chasing other animals to bite them."

On the whole, "Surgeon in Nepal" will appeal to a wide public since it is written simply, without unexplained jargon, and often in a very down-to-earth manner. It is written by a man devoted not only to its people but also to hard and often exasperating work.

P.P-J.

Examining the Nurses

Within the next few months the new type of practical final examination for Nurses will be introduced throughout the country. This system is an attempt to create a realistic environment for the candidates instead of the somewhat artificial situation which has existed for many years. It is also a sign that the cycle has now fully rotated in that individual hospitals will be assessing their own students, as in the days prior to State Registration.

In theory, then, this should prove to be a far superior method of affording qualification. However, there is at present one severe complication. There is a gross shortage of registered examiners. The result of this is, of course, very evident, but why should this situation have arisen, and what can be done to rectify the matter?

The first of these questions should be considered before the second one. Whereas some hospitals have made adequate preparation by introducing this type of examining and organising courses to train examiners, others it appears will greet the occasion totally unprepared. The Ward Sisters will have no conception of what is entailed and will find the system very difficult to organise.

In addition to all this, there does appear to exist a certain reluctance amongst some people to apply for registration, despite having attended the required course and otherwise having the necessary qualifications. Some more senior nurses appear to be of the opinion that there is something degrading about completing a form and attending an interview. They feel that long service as a Ward Sister should provide automatic registration. This, of course, is not, and should not be the case. If it were, the student nurses would have every right to question the validity of the examination and the authority of the examiners. Amongst the younger nurses is the fear that registration will prove too onerous, and place even greater restriction on freedom, such as they have, to choose holidays. Already these have to be expertly dovetailed and further restrictions will merely serve to antagonise.

However, the fact remains that the nurses have to be examined. If people continue to desist from making applications, there will be insufficient registered examiners and thus the burden will fall very heavily on those who have accepted their responsibilities. In a large hospital there may be 700-800 hours of examining each year to be undertaken. (Providing, of course, that nobody fails any section.) This cannot be completed thoroughly by those already available.

How then are the hospitals to increase their examiners? There are surely a few practical solutions. Firstly, how many are checking that those of their members who have attended a course on examining have, in fact, applied to the General Nursing Council? Why do they not allocate time during the course for completing the forms? These could then be despatched in bulk, thus ensuring that all had complied

and affording ease for those who do not feel moved to walk to a Post Office or to buy a 3p stamp. This would also obviate the need for a follow-up system which is rarely if ever foolproof.

In addition, how many hospitals are asking prospective Ward Sisters during the interview, whether they have registered. If this were to become general practice there would be a distinct move to become registered. If it became impossible to obtain a post without this qualification it would become a case of needs must!

Finally, could not hospitals be permitted to place their registered Ward Sisters on the salary scale one year in advance of that on which they would normally stand? In effect that would give a financial incentive of over £50 when the £7.50 already agreed to is included. This for most would serve as a considerable encouragement.

Action will have to be taken very shortly. If we are unable to examine the nurses there will soon be none who is qualified at all. In addition, if school-leavers see that they cannot take their examinations they will not apply for training. The Staff situation will then worsen.

It is essential for trained nurses to accept their responsibilities in this field. If they refuse they will only be aggravating a situation which already is extremely fragile, and also antagonise those of their colleagues who are attempting to carry the burden of providing an efficient system to ensure qualification of student nurses.

CORRESPONDENCE

"The Rites of the Unmarried"

SIR,—Your editorial on the "Rites of the Unmarried' certainly makes very interesting reading, and there must be few who will not agree that it is a trifle odd that so eminent a churchman as the Bishop of Leicester should go on record with the sentiment that doctors should take over the age-old role of the Church in laying down a code of morals for the guidance of the young. Had he contented himself with saying that medical men are in the best position to explain the problems of venereal diseases to their young patients, then no one would disagree; to offer the optimistic prayer that these same experts should unanimously condemn pre-marital intercourse is quite another thing.

There can be no doubt at all that many doctors do still recommend the virgin state to their young patients, but it is also true that many of their brethren (not to mention their sisters) accept that such a circumstance is not altogether common in this permissive age. Here we are not dealing with a matter such as the use of antibiotics in preference to a decoction of couch grass to get rid of infections of the urinary tract, but with a matter of morals —the accepted and traditional area of the church that is represented by the Bishop.

In the matter of moral judgment there will probably be almost as many differences of opinion as there are names on the medical register. The fact that a man has passed all his examinations and qualified as a doctor surely

does not imply that he has also successfully undergone a test which gives him the right to dictate morals to his patients. Indeed, current experience in the matter of legal abortions clearly indicates that legislation will never be able to dictate to the medical man with a conscience.

The role of the doctor in society is a changing one—this one must accept—but let us hope that the day may be far removed when the Church can abrogate its moral responsibilities merely by saying that, in today's society, the doctor has taken over the role of the "priest of the new denomination". What, one wonders, would the attitude of that same church be if the G.P. came to the decision that Mrs. Smith's new-born baby was a weakling and should therefore be left exposed on a mountainside?

Maybe the Bishop should take due note of your other editorial: "Of Cabbages and Weeds"? There seems little doubt that, did he but stand behind the counter of an ecclesiastical health store in Leicester, he would find himself —if Professor Butterfield's survey proves anything at all—in a position to spread his gospel to an incredible number of people. It is likely, if my information is correct, that more people go to health food shops in Leicester than listen each week to the episcopal sermons in that same city; maybe some of them would be willing to accept a text on pre-marital virginity with their dandelion and burdock?

Very truly yours,

GERARD MANN.

"Ashleigh,"
32, Grimwade Avenue,
Croydon, CR0 5DG,
Surrey.

SIR,—Whilst agreeing with the Editor's comments in the *Gazette* of 31st July, 1971, in their disagreement with the Bishop of Leicester's statement that doctors rather than clergymen should advise young people against sexual experimentation before they are married, I disagree with the muddled and muddling comments that followed.

Fascinating though the sexual practices of certain African tribes are, they are little related to sexual morality in Britain and most of Western Society. Confinement of sexual intercourse within marriage in these countries appears from history to be based more on Christianity and the teaching of Jesus on the positive side: "A man shall leave his father and mother and be joined to his wife, and the two shall become one flesh," etc. and on the negative side in His denunciation of fornication (sexual abuse including sexual intercourse outside marriage). Although Christians at several points in history, notably with the Puritans and in the Victorian era, have been at fault in considering sex as rather sinful; the Hebrew tradition as regards sex was healthy and earthy—little akin to the Greek's ideals of total abstinence on the one hand and sexual abuses on the other. The early Christians stood out from their pagan surroundings in their sexual morality.

In our present society it seems that on the one hand there is a cry for sexual freedom for all and on the other fears, especially from the sociological, paediatric and psychiatric standpoint, of breakdown of the family unit and insecurity within it, often in the final analysis the problem being of a sexual nature.

Of course, moral judgment and advice are or should be the Clergyman's realm rather than the doctor's but patients often seek moral advice from their doctor, maybe under another pretext, and even expect, on occasion, moral judgment. The dangers of promiscuity, and not just of venereal disease and pregnancy, but also of emotional disturbance and psychiatric disorders arising especially in the young girl, are also the realm of the doctor's consideration. The doctor, too, is a human being dealing with human contacts and problems, not an impartial scientist with medicinal or surgical remedies for all, and his views and advice are always partly coloured by his personality and moral

code. He will be expected to advise the young teenager as to whether to go on the Pill or not; to help a frigid woman in a marriage partnership; to help salvage a marriage which, disastrously for the children, is heading for divorce, and many such other problems.

Greed, lust and fornication are unpopular sins today. Indeed, sin itself is an unpopular word. It seems that we ignore the Maker's instructions to our peril.

As a postcript, I think we would do well to ponder one of the leaders in the latest B.M.J. (31st July, 1971). Of course, as the Editors imply, the solution is not easy, but it appears someone, somewhere needs some moral courage.

Yours faithfully,

ROS DISMORR.

East Wing,
Guy's Hospital.

White Coats for Students

SIR,—Having taken an active interest in the "Prevention of Cross-infection" at St. Olave's and New Cross Hospitals for many years, and tried to teach same to Nurses, Students and House Officers, I would like to support the plea for "white coats" not only for students, but all medical staff on the wards of Guy's Hospital Group.

There is no problem, as I see it, about confusion of "who's who", as many hospitals use the colour system of name badges.

Cross-infection, when it occurs, causes much dislocation and great expense to the hospital service, often entailing uneconomic bed occupation—therefore anything that can save money indirectly, as well as producing a better "shop window" should be encouraged.

Yours faithfully,

JANE M. FULLERTON,
Consultant Pathologist.

St. Olave's **Hospital,**
S.E.16.

SIR,—Your revival of the arguments concerning white coats for students is most welcome, as it is now three years since the failure of the last attempt to institute them.

Quite by coincidence, I decided to wear a white jacket myself in the hospital last week and I have been supported in this venture by another person on my firm. Our reasons for doing so are exactly the same.

(1) The staff to whom we spoke all seemed agreeable and in fact are now enthusiastic about us wearing them.

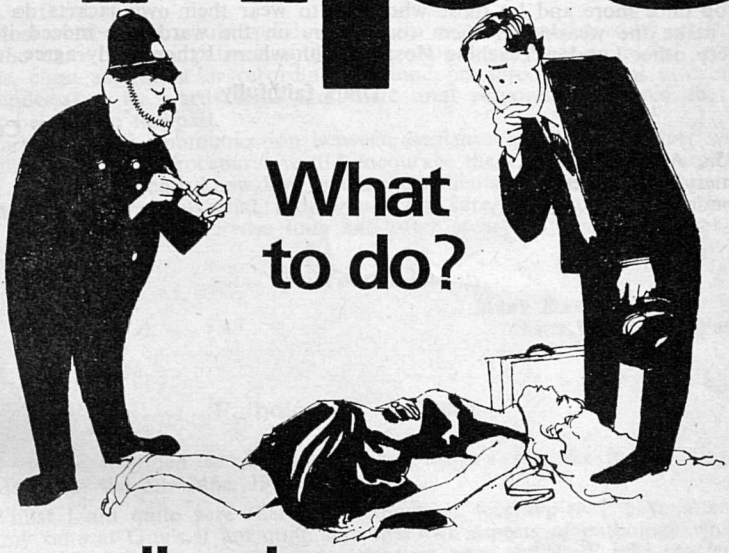
(2) The wear on clothes in a hospital is immense. I find I have to have my suits cleaned at least once a fortnight, and this is costly. A white jacket does have to be laundered regularly, but the costs are much lower and there is no comparison with the outlay for a new suit.

(3) The large pockets in white jackets are much more convenient for carrying stethoscopes, etc., which are necessary for ward duties.

(4) Most important as far as the hospital is concerned is the question of hygiene. A clean white jacket is clearly preferable to a suit which has just come from London Bridge. On Victoria ward, where I work at present, the nurses have a clean apron every day, and these never leave the ward. This attempt at cleanliness seems pointless if the students can come and go as they please in their everyday clothes. In fact, of those to whom I have spoken, Ward Sisters seem keener than the rest of the staff for students to wear white jackets on the wards.

There is clearly no point in restricting the wearing of white jackets to the wards only. There is very little hanging space available, and after all

mps



medical
protection
society est 1892

Unlimited legal aid
and indemnity against
professional hazards
throughout the world
(except U.S.A.)

Secretary Dr. H. A. Constable. Head Office
50 Hallam Street, London, W1N 6DE. Tel: 01-580 9241
or Regional Secretary Dr. P. G. T. Ford
Regional Office: 30 Park Square, Leeds 1. Tel: 0532 42115-6

housemen wear their coats wherever they go, so can there be any reason to stop students wearing them in the Spit, or in the Park?

The question of identification is also raised in your article. If short jackets are worn, then surely this is enough to distinguish the students. I can see no good reason for name badges on long coats either, for their absence would distinguish students, too. Also, they add to the expense of the project.

All students are given a locker in the hospital, so there is no problem of overnight storage, and the coats need not leave the premises, except for laundering.

Most of the students to whom I have spoken about this subject seem thoroughly in favour of jackets being worn and some intend to purchase them in the future for the same reasons I have stated. However, I feel that the majority are not prepared to invest in the jackets themselves and will only wear them if they are provided.

The only answers to the problem seem to be either to let the matter drop once more and let those who wish to wear their own jackets do so, or to make the wearing of them compulsory on the wards—as indeed it is in every other London Teaching Hospital with whom I thoroughly agree.

Yours faithfully,

T. P. CUTLER.

185a, Ashley Gardens,
Emery Hill Street,
London, S.W.1.

Nurses' Lament

SIR,—I am in no position to measure Dr. Hunter-Craig on his ability as a teacher!

However, as a Sister who has the dressers from four firms, seniors and juniors on the ward, I am constantly surprised at the general lack of interest shown in the patients' progress and well-being—even in the surgery performed, apart from the genuinely interested minority.

The term "dresser" originated when the student had the responsibility of dressing his patient's wound daily, and was able to give a good account to the Consultant when questioned about the patient. These days dressing on wards is mainly undertaken by the nursing staff, the student members of which need the experience. There is no reason, however, why the dresser shouldn't observe this procedure and learn something of dressing and bandaging techniques. There always seems to be a cry of despair from house officers who never learnt these procedures and are expected by the patient to be competent at them.

Most ward sisters would welcome the help students could give by assisting with the care of their patients undergoing procedures such as blood transfusions, chest aspiration or recording of blood pressure which was always a task undertaken by ward clerks and their total responsibility—even that I gather belongs to the past.

Perhaps closer communication between Registrar and House Officer with students on practical procedures would encourage them to participate more.

If the students only knew how much the patients appreciate their interest and time spent in a daily chat, they would, I'm sure, make a more concerted effort to brighten the otherwise long and often weary day of the patient in hospital.

Yours faithfully,

MARY DAVIDSON,
Sister, Mortimer Ward.

Pathologists' Lament

SIR,—I was horrified to read Professor Adams's remarks in the Guy's *Gazette* of the 5th June, 1971.

Whilst I am quite sure that the methods of teaching may have altered since my time at Guy's, I am quite sure that two aspects of pathology which have probably helped me most in my practice were the daily post mortems with the maxim that "one should follow one's patients to the P.M. Room", and also what used to be referred to as the finest pathological museum in Europe. I think that the many hours I spent in the Gordon Museum with my Dible pathology book have enabled me to readily visualise the disease from which my patient is suffering.

May I suggest that the students of today would do well to explore the Hospital grounds and seek out the Gordon Museum?

Yours sincerely, etc.,

Dr. C. D. CHILVERS.

P.O. Box 14,
Wairoa,
Hawkes Bay,
New Zealand.

Recruitment of Dental Students

SIR,—With the increase in the intake of students to medical schools following the recommendations of the Todd Report, the number of suitably qualified candidates applying to enter the dental schools of this country may well decline. For this reason it is becoming more and more important that schoolchildren are made aware of the nature and scope of a career in dentistry. To this end many schools in the South-East have been invited to send parties to visit the Dental School and members of the staff have attended careers conventions and addressed assemblies of pupils in schools.

Although a large number of the candidates applying for admission has been helped by advice from their dental practitioners, we have not as yet sought the assistance of Guy's graduates in our recruitment programme. It would be most helpful if we could form a panel of Guy's men and women willing to liaise with careers teachers and to talk at school careers conventions. The South-Eastern counties provide our principal catchment area and if anyone living in this area is willing to act as a dental careers adviser and would be kind enough to write to me, I will let them have further details of our plans.

Yours faithfully,

D. J. NEILL,
Sub-Dean of Dental Studies.

Guy's Hospital,
Medical and Dental Schools,
London Bridge S.E.1.

Lunch-time O'Schultzberger

SIR,—In answer to Mr. Schultzberger's letter concerning the closing of the bar at lunch-time, the reasons for this, as he implied, were financial.

In the nine months between August 1970 and May 1971 the bar lost in the region of £2,900, while prior to this it was ticking over at a minimal profit.

The cause of such a loss had not been pinned down to any one source and it seems that must be put down to a multiple pathology ranging from inefficient accounting to the loss of several hundred pounds' worth of glasses.

However, one of the many things which came out of our investigations was that the prices charged for the food at lunch-time did not adequately cover the additional costs of opening with four barmen, drawing off of eight pumps and spillage for what was only a two-hour period. Hence, one of the decisions passed by the Students' Club Council was to close the bar, at lunch-times as a temporary measure.

This was passed by the majority of the Students' Club on the advice of the bar committee and our accountants, and not, as has been suggested to me on numerous occasions, a conspiracy to shut the bar at lunch-times to bring back custom to the Spit.

What the student body must start to appreciate is that the bar is not a charity and although it is supposed to be run on a minimum profit margin it is not going to open to lose money. In spite of Mr. Schultzberger's cynical remarks, £2,900 is a considerable amount of money to a bar which has only made around £500 profit in the last five or so years and if the students want lunch-time openings they must be prepared for two things.

Firstly, to pay more realistic prices, bringing us somewhere nearer those of the Grapes and other local pubs and secondly, they must accept that the bar will not open at times when custom is not adequate to pay the wages, for example out of pre-clinical terms.

This being the case, and assuming that our figures for the next few months show a trend for the better, then I am hopeful that we can start lunch-time openings on some sort of basis in October.

Lastly, may I apologise to those who were interested, and did not know the plight of the bar's finances for not making the situation better publicised. We have had circulated on two occasions hand-outs in the East Wing but these were obviously not adequate and in future we will try to keep you better informed.

Yours sincerely,

ROGER ASHMAN,
Wine Sub-Committee

Students' Club,
East Wing,
Guy's Hospital.

The Navy is offering twenty-five medical cadetships this year. What are your chances?

Having passed your 2nd M.B., it all depends on you.

For our requirements are not simply your medical qualifications – but also the way in which your personal qualities match up to the demands of being a medical officer in the Royal Navy.

You see, as the only doctor on board, the entire medical responsibility for the ship's officers and men is yours. You might for example be somewhere in the Arctic or deep down in a nuclear submarine. In any emergency you are pretty well on your own. And that calls for some very special qualities.

But you're more than just a doctor.

Above all you are a naval officer – with the travel, the satisfaction and the full, rewarding life that every naval officer enjoys.

Of course all this happens after your registration.

In the first place, to qualify for a medical cadetship, you must pass your second M.B., or equivalent. After that you must be selected, following a Board interview.

Then while still at medical school, you are just like any other student. Except that we pay your fees and give you a guaranteed salary of £1,697 a year in the rank of Surgeon Sub-Lieutenant.

When you qualify you can spend your pre-registration year either at your hospital or one of ours.

After which we promote you to Surgeon Lieutenant, your pay goes up to £3,249 a year and you then begin your short-career commission with us for five years. When you leave us you'll take a lot of useful experience with you – together with a generous tax-free gratuity of at least £1,400.

In addition to 2nd M.B. students, the Navy also enters qualified doctors for a 5-year short-career commission. (Your application should be made during or after pre-registration year.)

Write now to Surgeon-Commander F. M. Kinsman, R.N., (26 AZ), Dept. of the Medical Director-General (Navy), Empress State Bldg., London, S.W.6, and tell him your age and qualifications. In return he'll tell you more about the advantages of applying for a medical cadetship or commission with the Royal Navy.

RN ROYAL NAVY

Arnold : the truth

SIR,—I am sorry to see that Arnold, my younger brother, has chosen to nail his colours to the mast of the Student Revolutionaries, and that you should have allowed him to use your hallowed pages to do so.

I would like to take this opportunity to assure your readers that such conduct is not typical of our family. My late uncle, Yuri Schultzberger, after whom Arnold was named, often used to say: "One swallow doesn't make a spoilt broth, but many hands shouldn't throw stones"; and I think most of us would surely agree with this.

Arnold has chosen, for reasons best known to himself, to cast doubts on the reasons for closing the bar in lunch times. "Let sleeping scandals lie," Yuri would say, thumping his fist on the linoleum, and who are we to dispute that?

Has it never occurred to young Arnold that there might be very good reasons why the bar should have lost so much money? If people continue to ask embarrassing questions, someone will eventually have to answer them—is that what he wants? How dare he question our time-honoured methods of reactionary capitalism, which have served some of us so well for so long?

Yours sympathetically,

CONSTANCE SCHULTZBERGER, M.S.

Rose Cottage,
Schnipfelstrasse 27,
Leichtenstein.

WHITE COATS FOR MEDICAL STUDENTS AT GUY'S

In view of the extensive publicity and comment concerning this topic, the Students' Club Council has decided to test student opinion by way of a poll.

In the next few days all firms will be asked to complete a questionnaire to enable information, particularly regarding laundering, to be assessed.

Students' help with this undertaking would be most useful. Forms are available from Lynne Hampson, East Wing.

SPORT

SPORTS COMMENT

Much has been written in the popular press in recent years about the dull defensive cricket so often seen at the county grounds. Stimulated by the falling attendances at county matches, the one-day Sunday league matches were established.

Last Sunday I witnessed a display which would have gladdened the hearts of all the enthusiasts of brighter cricket had they been there to see it. In a single over, H. Holliday, whilst batting for the 2nd XI, managed to hit a four, three consecutive sixes and to make the journey back to the pavilion. This match also provided the opportunity for M. Samje to achieve a career best in scoring 72 not out and in taking 7 wickets in 8 overs.

The 1st XI are enjoying a better than average season with twelve victories out of twenty-four matches. One of their most recent successes is the defeat of Bognor C.C. whilst on tour, a match which they have failed to win on the last five occasions.

CRICKET REPORT

MATCH v. NOMADS

Saturday, 10th July, at H.O.P.

Guy's lost by 5 wickets.

Guy's (ably led by A. Holland) won the toss, and after much deliberation, decided to bat. This seemed to be a good move because the openers, A. Gillham and A. Holland, were undefeated at lunch with 72, which was a very reasonable score considering the pitch was giving some help to the bowlers.

After lunch they increased their partnership to 123, before Gillham was out for 62. Clifford Jones scored a quick 35 and Holland was eventually out for a very useful 64.

Guy's were thus able to declare at 207—7. Unfortunately, the Guy's bowling attack was not very strong, and they were not able to contain the Nomads' batsmen, who managed to win off the first ball of the last over. The best bowler for Guy's was J. Scoble, who took 2 for 43.

HOSPITAL INFORMATION

THE BOARD OF GOVERNORS OF GUY'S HOSPITAL

Invite applications for the appointment of Middle Grade **Registrars** as follows:—One in General Medicine to work in the Guy's Group of Hospitals, one to work in Renal Medicine and one to work in the Department of Neurology for the period 1st October, 1971 to 30th September, 1972. Application forms are obtainable from, and should be returned to, The Superintendent, Guy's Hospital, London, S.E.1, not later than **27th August, 1971.**

THE BOARD OF GOVERNORS OF GUY'S HOSPITAL

Invite applications for the appointment of **Registrar** in Renal Medicine for the period 1st October, 1971 to 30th September, 1972. Application Forms are obtainable from, and should be returned to, The Superintendent, Guy's Hospital, London, S.E.1, not later than **27th August, 1971.**

THE BOARD OF GOVERNORS OF GUY'S HOSPITAL

Invite applications for the appointment of Middle Grade **Registrar** in Neurology for the period 1st October, 1971 to 30th September, 1972. Application forms are obtainable from, and should be returned to, The Superintendent, Guy's Hospital, London S.E.1, not later than **27th August, 1971.**

GUY'S HOSPITAL BOARD OF GOVERNORS AND THE SOUTH EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited for the appointment of **Senior Registrar** in E.N.T. Surgery to commence on 1st September, 1971, or as soon as possible thereafter, until 30th September, 1972. The successful candidate will work at Lewisham Hospital. Application forms are obtainable from, and should be returned to, The Superintendent, Guy's Hospital, London, S.E.1, not later than **27th August, 1971.**

THE BOARD OF GOVERNORS OF GUY'S HOSPITAL

Applications are invited for the appointment of **Senior House Officer** in Clinical Pathology at St. Olave's Hospital to commence on 1st October, 1971 until 30th September, 1972. The post offers good general training in pathology and further information may be obtained by telephoning Mr. Cleak in the laboratory of St. Olave's (Telephone 237 4311 Ext. 101). Application forms are obtainable from and should be returned to the Superintendent, Guy's Hospital, London, S.E.1, not later than **27th August, 1971.**

THE BOARD OF GOVERNORS OF GUY'S HOSPITAL

Applications are invited for the appointment of locum medical **Registrar** at St. Olave's Hospital for the period 3rd—27th September, 1971 inclusive. Applications with the names of two referees or enclosing two recent testimonials should be sent to the Superintendent, Guy's Hospital, London, S.E.1, within one week.

THE BOARD OF GOVERNORS OF GUY'S HOSPITAL

Applications are invited for the appointment of locum **Registrar** in Anaesthetics to commence as soon as possible to work in the Guy's Group of Hospitals. Applications with the names of two referees or enclosing two recent testimonials should be sent to the Superintendent, Guy's Hospital, London S.E.1, within one week.

GUY'S HOSPITAL HOUSE APPOINTMENTS

House Physicians

Dr. Mann, Dr. Scott, Dr. Clark and Dr. Grahame — Mr. J. A. H. Wass, 3 *months*; Miss D. C. T. Watson, 6 *months*

Dr. Hardwick, Professor Trounce, Dr. Cameron and Dr. Ogg — Miss S. A. Lange, 3 *months*; Mr. J. D. Mackay, 6 *months*

Dr. Houston, Dr. Knight, Dr. Deuchar and Dr. Grimble — Mr. B. R. Kenning, 3 *months*; Mr. H. J. Klass, 6 *months*

Professor Lessof, Dr. Joiner, Dr. Burry and Dr. Sowton — Mr. R. J. Wainwright, 3 *months*; Mr. R. G. A. Behrman, 3 *months*; Mr. W. F. Jackson, 6 *months*

House Surgeons

Professor Sir Hedley Atkins — Mr. R. G. Jezzard, 6 *months*

Mr. Blackburn and Dr. Wayte — Mr. T. W. Higenbottam, 6 *months*

Mr. Lawrie — Mr. A. J. Camm, 3 *months*

Mr. Glover and Mr. McArthur — Mr. J. D. Wrout, 6 *months*

Mr. Beard — Mr. D. W. Gorst, 6 *months*

Mr. Maynard and Dr. Wayte — Mr. P. W. L. Ribet, 3 *months*

Mr. Ellis — Mr. J. R. Pepper, 6 *months*

Mr. O'Flynn and Mr. McArthur — Mr. D. McDiarmid, 3 *months*

House Surgeon to the Breast and Plastic Surgery Units

Miss A. P. Hill, 3 *months*

Gynaecological House Surgeons

Mr. S. R. D. Coles, 3 *months*

Mr. P. G. Jackson, 6 *months*

Throat and Ear House Surgeons

Mr. G. T. Cheney, 3 *months*

Miss S. M. Brown, 6 *months*

Orthopaedic House Surgeons

Miss I. D. Cormac, 3 *months*

Mr. N. A. G. Jones, 3 *months*

Mr. D. A. Raper, 6 *months*

Mr. D. R. Jones, 6 *months*

Each Orthopaedic House Surgeon will spend 6 weeks at New Cross Hospital.

S.H.O. to the Renal and Transplant Units
Mr. A. J. Rees
6 *months*

Genito-Urinary House Surgeons
Mr. M. M. Henry
3 *months*
Mr. J. S. N. Anderson
6 *months*

Children's House Physicians
Mr. M. F. H. Bamford
3 *months*
Mr. B. Dick
6 *months*

Casualty Officers
Mr. N. J. Lattimer
3 *months*
Mr. J. A. R. Pook
3 *months*
Mr. D. A. Jones
6 *months*
Mr. P. H. Reinhold
6 *months*
Mr. M. E. Taylor-Pearce
6 *months*

Resident Obstetricians
Mr. R. W. Neale
3 *months*
Appointed to be announced later
6 *months*

Neurological House Physician
Mr. C. R. A. Clarke
6 *months*

Dermatological House Physician
Mr. R. J. G. Rycroft
6 *months*

House Physician in Child Psychiatry
Miss R. M. Doody
3 *months*

House Surgeons to the Thoracic Unit
Mr. A. V. Lalani
3 *months*
Mr. J. M. Dussek
6 *months*

House Physicians in the Department of Psychological Medicine
Mr. M. H. Mubbasher 1.9.71—31.3.72
Mr. M. Redfern 1.9.71—31.3.72

Resident Anaesthetists
Mr. R. P. H. Dunnill
3 *months*
Mr. M. A. Knight
3 *months*
Mr. J. R. Wedley
6 *months*
Mr. G. S. MacMillan
6 *months*

Senior House Officers to Nuffield House
Mr. M. F. Shiu
3 *months*
Appointed to be announced later
6 *months*

Children's House Physicians at Evelina Hospital
Mr. A. C. L. Fraser 1. 4.71—30. 9.71
Mr. K. G E. Brown 1. 6.71— 30.11.71
Miss S. E. Read 1. 8.71—31. 1.72
Mr. S. Kraemer 1.10.71—31. 3.72

Casualty Officers at Evelina Hospital
Mrs. C. E. McAuliffe
3 *months*
Mrs. S. Lena
6 *months*

ST. OLAVE'S HOSPITAL
House Physicians:
Mr. T. J. Storrs
3 *months*
Mrs. C. G. Bissenden
6 *months*
House Surgeon:
Mrs. F. E. Jones
3 *months*
Senior House Surgeon:
Mr. D. J. Johnson
3 *months*

Gynaecological House Surgeon Appointed to be announced later.
6 *months*
S.H.O. in Psychiatry:
Mr. S. D. Joshua
6 *months*

NEW CROSS HOSPITAL
House Physician in General Medicine and Geriatrics:
Miss M. J. Van Essen
3 *months*
Mr. J. S. Polkinhorn
6 *months*
Mr. A. B. Murgatroyd
6 *months*
Orthopaedic House Surgeons see under Guy's.
Senior House Officer to Rehabilitation Unit:
Mr. A. Bhoomkar
6 *months*

BECKENHAM HOSPITAL
House Physician:
Miss G. L. Hoare
6 *months*
House Surgeon:
Miss G. A. Redding
6 *months*

GREENWICH DISTRICT HOSPITAL
House Physician to Dr. Mallinson:
Miss C. Thorne
3 *months*
House Surgeon to Mr. O'Flynn, Mr. Wilson, Mr. Hollis and Mrs. Wongraf:
Mr. D. A. Rosenberg
3 *months*
House Surgeon to Mr. Eldin and Mr. Cobb:
Mr. P. J. Marriott
6 *months*

HITHER GREEN HOSPITAL
House Physicians in General Medicine and Infectious Diseases:
Mr. C. C. Baker
3 *months*
Mr. R. C. Fieldsend
6 *months*

LEWISHAM HOSPITAL
House Physician to Dr. Price:
Mr. J. M. Morsman
3 *months*
House Surgeon to Mr. Lynn Evans:
Mr. D. Bellamy
3 *months*
House Physician to Dr. Roberts:
Mr. C. J. Noble
3 *months*
House Surgeon to Mr. Ivo-Smith:
Mr. B. R. Crichton
3 *months*
House Surgeon to Mr. France, Mr. Bingold and Mr. Monty:
Mr. R. H Mackay
3 *months*
House Surgeon to Mr. Le Brun:
Mr. J. D. Wheal
6 *months*
House Physician to Dr. Llewellyn Smith:
Mrs. L. J. Rockall
6 *months*
House Surgeon to Mr. Cavendish:
Miss P. L. Pantin
6 *months*

MILLER HOSPITAL
House Physicians to Dr. Hartley and Dr. Bassasone (S.H.O.):
Mr. M. N Vellacott
3 *months*
Mr. M. A. Mansell
6 *months*
Mr. J. D. Martin
6 *months*

House Surgeon to Mr. Candy and Mr. Gwynne Evans:
Mr. J. K. McKenzie
3 *months*
House Surgeon to Mr. O'Flynn and Mr. Fyffe:
Mr. G. Peters
3 *months*
House Surgeon to Mr. Eldin:
Mr. J. R. H. Ross
6 *months*

ORPINGTON HOSPITAL

House Surgeon with Dental:
Mr. A. R. Valentine
3 *months*
House Surgeon with E.N.T.:
Miss R. C. S. Dow
3 *months*
House Surgeon with Orthopaedics to Mr. Boxall and Mr. Lam:
Mr. S. D. Horsley
3 *months*
House Surgeon with Gynaecology:
Mr. J. G. G. Hanley
3 *months*
House Surgeon to Mr. Walker-Brash and Mr. Lam:
Mr. R. D. Ward
3 *months*

PEMBURY HOSPITAL

House Surgeons to Mr. Gibson and Mr. Lavy:
Miss R. J. Thorburn
3 *months*
Mrs. A. M. de Carteret
6 *months*
House Physicians to Dr. Miller and Dr. King:
Mr. A. I. Attwood
3 *months*
Mr. J. L. Bates
6 *months*

ST. HELEN'S, HASTING

House Physicians:
Miss A. Ironside
3 *months*
Mr. J. A. Dalziel
6 *months*

ST. NICHOLAS, PLUMSTEAD

House Physician to Dr. Scott:
Mr. N. Longhurst
3 *months*

P. J. HELLIWELL,
Superintendent.

PASS LIST

UNIVERSITY OF CAMBRIDGE

Final M.B.
June 1971
Part I

*A. N. Hooker
*P. G. Jackson
*J. A. Morgan
M. Reuben
*J. H. Turner
*Christine R. White
*D. G. Williams

Part II

*J. S. N. Anderson
N. C. Bartlett
*Susan M. Brown
*T. P. Burns
*J. A. Dalziel
*N. S. Davies
*Mrs. A. M. de Carteret
*R. C. Fieldsend
*A. N. Hooker
*P. G. Jackson
*W. F. Jackson
*R G. Jezzard
*H J. Klass
*J. D. Mackay
*P. J. Marriott
*J. A. Morgan
*J. R. Pepper
*J. S. Polkinhorn
*Georgina A. Redding
M. Reuben
*D. Rowley Jones
*J. H. Turner
*J. D. Wheal
*Christine R. White
*D. G. Williams
*J. G. Williams

*Qualified

UNIVERSITY OF OXFORD

B.M. B.Ch.
June 1971

*D W. Gorst
*R. J. Hay
*A. B. Murgatroyd
*D. A. Raper
*J. D. Wrout

2nd B.M.

D. A. G. Cook (Midwifery)
M. H. Davies (Surgery, Midwifery)
S. J. Farrow (General Pathology, and *Bacteriology*)

*Qualified

EXAMINING BOARD IN ENGLAND

Final L.R.C.P., M.R.C.S.
June 1971

Medicine

R. A. Burlinson
W. Edmonds
*P. R. Evans
*S. R. Hammond
*D. M. Hunt
*B. V. Martindale
*P. Matthews
*T. de F. Mendis
*G. L. Pryor
*J. H. Reynolds
*A. G. Scourfield
R. G. Thomson

Midwifery

N. K. Barber
A. J. G. Batch
D. N. Bateman
N. D. S. Bax
*Berenice R. Beaumont
*A. J. L. Brain
R. M. *Darling*
Rosalind M. Dismorr
G. C. Dunbar
Rosemary M. Ede
M. T. Fenner
J. A. Fleetham
Dorothy M. Frost
R. C. Gartell
D. M. Gillman
S. J. Golding
R. A. G. Goodhart
H. A. Goudarzi Langroudi
Lynne K. Hampson
I. D. Harrison
J. L. Hewlett
G. James
Lucinda L. Judd
J. K. Klosok
C. J. Lamb
A. M. Light
Avril A. Little
Anne E. MacFarlane
M. C. N. McNeil
C. J. F. Manning
*P. Mathews
Mahuaz Munir-Ahmed
Dilys A. Neville
D. J. *Palin*
R. G. Pietroni
A. J. Prisk
Sheila S. C. Rankin
D. R. Richardson
M. A. J. Rosenberg
C. J. Rudge
J. E. Scoble
M. M. Shaw
J. C. B. Shutes
P. J. E. Smyth
R. K. Stacey
I. D. Starke
M. A. Stodell
D. F. Stubbs
C. J. Thomas
S. G. Thompson
Hazel M. Tyson
Valerie J. Wass
R. W. M. Wright
N. O. Yerbury

Pathology

N. J. Astbury
N. K. Barber
A. J. G. Batch
D. N. Bateman
N. D. S. Bax
C. J. Bennett
R. M. Darling
Rosalind M. Dismorr
G. C. Dunbar
Rosemary C. Ede
M. T. Fenner
J. A. Fleetham
P. C. Gartell
S. J. Golding
H. A. Goudarzi Langroudi
I. D. Harrison
J. L. Hewlett
C. J. Lamb
Doreen A. W. F. Lee
Avril A. Little
Anne E. MacFarlane
N. C. H. McNeil
C. J. F. Manning
Dilys A. Neville
R. G. Pietroni
A. J. Prisk
Sheila S. Rankin
M. A. J. Rosenberg
C. J. Rudge
J. E. Scoble
M. M. Shaw
J. C. B. Shutes
P. J. Skinner
R. K. Stacey
M. A. Stodell
D. F. Stubbs
C. J. Thomas
S. G. Thompson
R. G. Thomson
Hazel M. Tyson
S. C. Wells
N. O. Yerbury

Surgery

*Berenice R. Beaumont
*A. J. L. Brain
*Penelope Brain
*Margaret L. *Cann*
*L. P. Harrison
*G. M. A. Heaton
*P. G. Jackson
*E G. Latimer-Sayer
*J. H. P. S. Sargent
*A. J. Scourfield
*A. J. *Shellim*
K. O. Thompson
R. G. Thomson

*Qualified

FINAL STATE EXAMINATION—JUNE, 1971

The following Nurses have passed the Examination:—

Adkins, E. A.
Allen, R. W.
Applin, C. A.
Barrett, H. R.
Battin, E. M. A.
Brindley, M. A.
Brooksbank, D. R. (née Baker)
Burn, F. E.
Davis, A. C.
Drozd, E.
Dunne, C. A.
Elton, S. M.
Fairrie, A. P.
Fenton, H. M.
Growcott, H. S.
Heath, P. J.
Hunter, J. C.
Hyam, L. F.
Jones, B. M.
Kind, S. H.
Knight, J. M. W.
Livingston, S. (née Nunn)
Locke, R. S.
Loye, M. H. B.
Malleson, A. L.
Myers, S. W.
Parker, S. E. M.
Pearce, D. M.
Pocock, C. L.
Read, G. Z.
Reid, C. I.
Ryan, J. M. T.
Scales, S. A.
Smalley, E. A.
Smith, J. C.
Sutherst, L. K.
Turner, J. J.
Vellacott, S. N.
Watts, P. J.
White, Bernard John
Whitehead, E. S.
Young, D. F.

THE CHARTERED SOCIETY OF PHYSIOTHERAPY FINAL RESULTS JULY 1971 PASS LIST

Miss R. J. Chamberlain
Miss V. M. C. Davidson, Credit
Miss S. Gray
Miss G. M. Hobbs, Credit
Miss S. M. Long
Miss C. A. Meadows
Miss J. E. Sheffrin

CHANGES OF ADDRESS

Dr. J. Hyatt Williams, 22, Grassmount, Forest Hill, London, S.E.23.

From 1st September, 1971: Steiner, Walter A. (Dental Officer—City of Exeter) private address: 22, Portland Avenue, Exmouth, EX8 2BS, Devon. Tel: 2970.

Dr. and Mrs. J. M. Brummitt, 7, Radnor Park, Corston, Malmesbury, Wilts.

Sister M. Trevelyan, S.R.N., S.C.M., 13B(1), Golding House, Claybrook Road, London, W.6.

PERSONAL

SENIOR REGISTRAR seeks furnished/unfurnished accommodation, S.E. London from 1st October, 1971 for 1/2 years: willing to pay up to £12 per week. Contact Dr. Stronthidis, Day Hospital, St. Helen's Hospital, Hastings, S/X. Tel: 7090 (Hastings).

BIRTH

LINDOP—On 14th June, 1971, to Kari (née Brachel) and Michael, a daughter, Tanya, a sister for Tom Christian.

DEATH

HIGGS—On Wednesday, 21st July, 1971, Edith Brenda Higgs, F.S.R.(T). Radiotherapy radiographer Guy's Hospital, 1943 to 1960.

We would like to remind our readers that all copy for inclusion in the "Gazette" must be received eight days before publication date.

Copy may be sent to us c/o The Front Lodge, Guy's Hospital.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, please indicate whether or not this should be published.

Personal notices 5p per word (pre-paid) (minimum £1.05).
Non-subscribers will pay £1.05 (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

EDITOR A. M. TURNER
NEWS EDITORS C. G. CHINERY and D. I. F. KELLEHER
SPORTS CORRESPONDENT A. M. ROYSTON
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TEN PENCE VOLUME 85 NUMBER 2169

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

There was no Number 2166.

PASSIM

Recently we have experienced football players loosening even more their customarily incontinent lips against restrictive referees. A professor and others have been beaten up and robbed on the underground in busy London. Since the Battles of Trafalgar Square in the mid-1960's, demonstrations by young people against most things and most people have become more and more violent. In Northern Ireland violence counters violence at all times. Metal staples have been shot by the crowd on to the pitch at football players. If the success of a film is graded by the amount of excitement and sympathy its heroes evoked, then Bonny and Clyde was one of the most successful films to emerge from the United States of America in the last seven years.

The pattern has emerged of a society with violence as one of its most common behavioural traits. Violence is both the solution to problems and an entertainment. Now it may be claimed that the violence in these cases is different in kind; that political aggression is quite different from the unjustified, wanton boot-slinging of thugs; that one is the natural and necessary method of removing intolerable burden and the other is an example of frustrations or vindictiveness, or cruelty. That distinction is superficially very attractive but is insidious, for in justifiying one form and condemning the other, the argument perpetuates the cause of the thuggery.

Recently, many young articulate people have adopted the view that violence, including murder, is necessary to free a country from oppressors. The argument extends to the killing of policemen in this country for being the defenders of the insentient capitalist society that pays them to preserve its institutions.

Violence is the foundation of societies. They are preserved from dreaded anarchy by a force of protectors. Enemies are caged away. The result is that those who feel themselves less privileged, and that has come to include the young who are now more than ever keen to control their lives while still young and zealous, feel that the only way to succeed is through violence. They certainly will not be permitted to change the distribution of wealth and land without a struggle with the rich. Should they succeed they will have to preserve their society with force. Should they fail they will remain squashed

but squealing. The frustrated will continue to adore football games in which players enact the violence against each other and against the rules that the spectators feel themselves. Attempts to stylise the game into a more gentle and skilful entertainment are in the wrong direction. More films will be made in the style of Bonny and Clyde, in which the excitement of shooting and killing bankers and policemen makes the lives of the heroes more attractive than the spectator feels is his life, even when the film is loaded with with moments of depression and fear and final retribution. The excitement of violence seems more attractive than dull submissiveness. A good evening's entertainment will continue to be an outing of pointless robbery with violence.

Our ruthless selves ensure a future of violence and hate.

The Student's Bar

The reaction of students to Mr. Roger Ashman's comprehensive and informative letter published in the last *Gazette,* has been a mixture of shock, amazement, and later disbelief.

Shock that the rumours which have been so rife were in fact true; amazement that this bar, the customary haunt of hordes of thirsty students, should make a loss; and lastly, disbelief that the loss could have reached such proportions. The figure of just under £3,000 is indeed considerable.

No doubt there has been much heart searching, to say nothing of figure juggling. It is to be hoped that the cause may yet be exposed; however, a cessation of these losses would appear essential to the continued operation of the bar. Our sympathies are with Ted Burrow, the resident barman, in this phase of uncertainty.

Enough of the past, what of the future? It was said that longer opening hours meant greater losses, thus have shorter hours, and less losses. It is hard to disagree with this wisdom worthy of Solomon, but we have also been told that capitalists usually rely on a profit which is somehow related to turnover.

The turnover of the bar, one would imagine, is considerable but most of the sales consist of draught beer on which there is little profit. The answer would seem to be to attract additional trade, particularly in the less busy periods.

What, then, are the chances of an extension of the present facilities in the style of a saloon bar, with better furnishings, to attract an evening trade. This would still leave an area for rugby crowds to pour beer over themselves, and yet provide a place for students, nurses and physiotherapists (cannot they be allowed in, regulations after all, are made to be "bent" or changed) to spend their time in more congenial surroundings.

The local hostelries provide the minimum service and yet make a living out of the large captive market at Guy's, how much more of an advantage has the bar in the East Wing to make a go of things with its closeness and low overheads.

The issue really at stake seems to be, is the students' bar a tradition which is worth keeping alive with new ideas, perhaps even new non-student management, or should it, like old soldiers, and presumably medical students, just be allowed to fade away?

This week Nigel Bax climbs down from his editorial throne after a year of producing the *Gazette*. His consistent energy and humour will be lost to our pages but now further enrich his medical studies. A new Assistant Editor will be appointed shortly.

In this and the next edition of the *Gazette* we are publishing four essays which were given in answer to a question in the Wooldridge Physiology Prize Examination. The question was, "Describe the discovery of a hitherto unknown organ in the Mediastinum." The inventiveness and correctness of the Physiology of the four essays, especially considering they were written under examination conditions, makes them excellent examples of the work of students at Guy's at present.

NEWS IN BRIEF

"Burning Warehouses"

The sound of multiple sirens was heard at Guy's last Monday afternoon. This is not, of course, a rare event, however on this occasion the number was rather excessive, and was not a preliminary to a crisis in casualty. The perpetrators were large, red vehicles with ladders and hoses, not the usual small white or grey ones.

The scene of the excitement was a warehouse on the nearby Hays Wharf, which provided London with one of the biggest blazes since the war. The warehouse was empty and due for demolition in the near future, the fire merely carried out the job rather quicker and sooner than anticipated.

The thought that crosses one's mind is whether another conflagration, somewhat nearer home, might speed the redevelopment of Guy's a little?

Excavations Below the Medical School

The meditations of the electron microscope, and the concentrations of visitors to the Gordon Museum, have recently been disturbed by the sound of pneumatic road drills breaking up the floor of the basement passage in the medical school.

The purpose of such activity is not, as has been suggested, to construct a subterranean cavern for pathologists to shut out the outside world, but to carry ducted warm air to the York Clinic. Things are looking up. So far, the urge on the part of staff and medical students to play with the exciting drills and power hammers has, we are told, been well restrained.

White Coats Again

The response to the questionnaire about white coats for students has been very good. However, to ensure as complete a coverage as possible of student opinion, it is hoped that all outstanding completed forms be returned as soon as possible.

Any firm which has not yet received a questionnaire is requested to apply to Lynne Hampson or Chris Chinery, East Wing.

Psychiatric Take-in

Escorting patients to other hospitals has long been regarded as the least pleasant aspect of Psychiatric take-in. This duty removed the student from his academic commitments and from his opportunity to see psychiatric emergencies as they presented. In recent months, students have been unavailable and bleeps have not been carried.

The Student Medical Education Committee have discussed the problem with the Dean, the Superintendent and Dr. Stafford Clark.

The first approach was to Dr. Stafford Clark and it was agreed that the accompanying of patients should be made voluntary. Students, in return, would be expected to carry bleeps and clerk and follow up their cases.

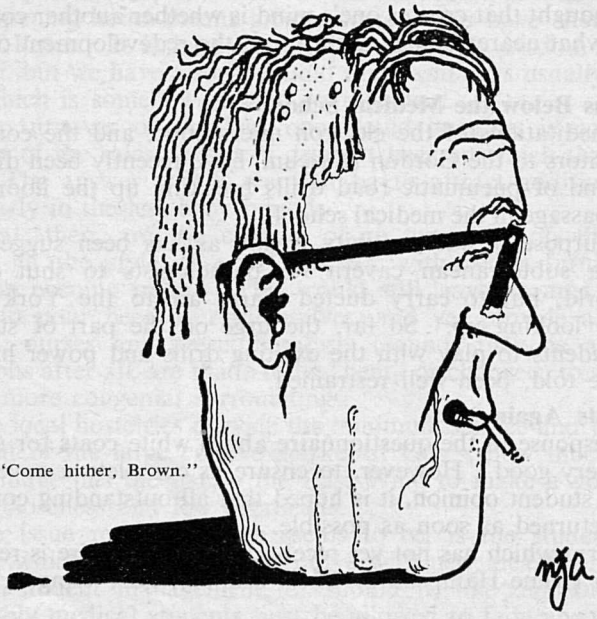
However, escort of patients by a responsible person was still necessary and it was suggested that students should be paid for this duty, while retaining the voluntary basis. The Dean and the Superintendent agreed to the new measures.

The payment will be £2.00 in addition to necessary travelling expenses. Psychiatric take-in students will be first on call, if they so wish.

A register of clinical and preclinical students who are on the telephone and can reach Guy's quickly will be set up to provide 24-hour cover. Interested students should contact the Emergency Psychiatric Registrar.

St. Christopher's

A few sub-lets are available until October at St. Christopher's. The waiting list for permanent tenancies is short and any prospective resident is assured of a short wait. Anyone wishing to make use of the marvellous facilities is invited to contact Mr. Lockton in the Accounts Department.



"Come hither, Brown."

Anaerobic Respiratory Cycles In Man

J. S. Tilley

The discovery was made of a hitherto unnoticed structure in the mediastinum of certain villagers on the west coast of Africa. A doctor had become interested in those villagers when he discovered mild amnesia in young men who had been swimming. He performed certain easy memory tests, whereby the subjects had time intervals of 15 minutes between memorising and reproducing the test, and found that short term memory remained intact provided that the subject did not swim during the interval. In nearly all cases those who did swim were unable to remember. Further examination showed that these subjects had unusually depressed basal heart and respiration rates, but that heart rate increased and respiration rate decreased relatively on oppressive wet days as from bright days. Further more it was noticed that these men preferred eating liquid to solid, and when solids were eaten the men chewed excessively and in some cases showed mild discomfort in swallowing.

Armed with this information the doctor persuaded the subjects to undergo routine testing. It was discovered that predictably there appeared to be an obstruction anterior to the oesophagus and posterior to the division of the main bronchus at T_4. This obstruction was revealed to be only partial by barium meal lateral X-rays. The obstruction was not calcific and could not be associated with any lung tissues, and this correlated with lack of any symptomatic evidence. No abnormal constituents could be found in the urine, but it was noticed that both in blood and urine there was a higher than expected value for metabolites in some, but not all subjects. Liver function tests were normal. As no comparable structure could be found in dogs, cats, rats or monkeys and as investigation beyond routine tests was refused by the subjects, an analysis of this phenomenon appeared to be blocked.

Further investigation showed the following:

(1) not all young men had the structure;
(2) it was not found in any children under 10 years.

It was concluded that it was a structure which was subject to changes in puberty and only in certain men. The first indicated some form of stimulating factor for its growth. The second required to find some common factor amongst the men who had it, and it was found that all these men were good swimmers, who had the remarkable ability to stay under water for long periods of time.

It seemed sensible then to conclude that in some way either water to skin contact enabled them to do this, or more likely, in the light of the fact that on oppressive days when atmosheric pressure was increased, variations in physiological standards were obtained, that this increase in pressure was the key factor. Thus experimental work was done.

(i) Heart rate, respiratory rate, 0_2 uptake, $C0_2$ output were measured synchronously as the subject stood under a stream of water.

(ii) The same factors were measured when the subjects' bodies (except head) were exerted to supra-atmospheric pressure. It was discovered that:

1. With just water the factors were unchanged.
2. If generalised pressure the heart rate went up slowly and respiration decreased.
3. 0_2 uptake and $C0_2$ output were decreased.
4. Metabolites in blood and urine soared.
5. Under local supra-atmospheric pressure, i.e. on legs, or hand etc. factors were unchanged.

The conclusion that these men were able to undergo, for limited periods of time, anaerobic respiration was finally proved to be true when the above and other experiments brought a cascade of interest and controversy from experimentalists and doctors all over the world. Post mortems have shown this normally vestigial organ to be a gland of the ductless endocrine variety which, on release of anaerobic stimulating factor from the skin after generalised supra-atmospheric pressure, causes release of a hormone from the gland which activates an enzyme "metabolase" which initiates a hitherto undiscovered anaerobic respiratory cycle potentially present in the cells of this man.

Workers have reported vestigial glands in certain men of those races who were not swimmers but none has been found in Europeans. It was concluded that the formation of the gland was genetically determined and provided that at puberty long periods of swimming and diving occurred the gland developed. Gland extraction and injection into the Europeans has never been attempted (because only humans are donors) so it is not known whether the characteristic gene is present in Europeans.

This discovery has bolstered world opinion that man has more affiliation to sea water than other mammals except the whale.

APOLOGIES

We omitted to mention in issues Numbers 2162 and 2168 that the photographs that appeared of Dr. Kauntze and the late Florence Taylor were taken by, and are the copyright of, Mr. F. J. Pitts.

We have to apologise to librarians for jumping from issue Number 2165 to 2167. It was our mistake. There was no issue Number 2166.

Discovery of the Atheroma Factor

P. G. Davies

For many years the correlation between serum β lipoprotein levels and atheroma has been realised. It has also been found that polyunsaturated fats bring about a reduction in the β lipoprotein level. Atheroma has a geographic variation which is seemingly related to the state of development of the various parts of the world. The disease is particularly prominent in the western countries where the pace of living is high and the population has a high intake of carbohydrate and animal fat.

P. Bricthic has put forward a hypothesis in which he states that atheroma is due to a deficiency of a certain hormone which activates an enzyme system which in turn reduces the serum β lipoprotein level. His consequent work has brought out a considerable number of findings to support his view.

In his experiments, Bricthic decided to use apes because of their anatomical and physiological similarities to humans. From what evidence he could gather he found that atheroma was an extremely rare cause of death in apes living in the free state. Bricthic therefore suggested that this hormone (the atheroma factor) was accomplishing its normal physiological rôle in the ape.

First of all he wanted a try to show the existence of the atheroma factor. He found that if he raised the serum β lipoprotein level of the ape artificially, it would be rapidly reduced to normal levels. One day, while working on these β lipoprotein clearance experiments, there was a high level of extraneous noise in his laboratory and Bricthic found that the rate of clearance of the β lipoprotein had approximately doubled. Bricthic decided to determine the apes' heart frequency and found it was considerably raised. From this it appeared to Bricthic that there might be a relationship between the rate of clearance of β lipoprotein from the blood and the heart frequency. Further work in this direction reinforced this finding and so led Bricthic to suggesting that the amount of atheroma factor released increased with an increase in heart frequency.

Meanwhile, V. Luscrue, an anatomist working in the United States, had found that attached to the apex of the heart was a small piece of tissue covered in fat which was structurally quite different from cardiac muscle. On histological examination it was seen to have in its cells large vacuoles which suggested that it might have some secretory function. The tissue could be seen to be in direct communication with the muscle of the apex which in turn was in communication with the fibres of the Purkinje conducting system. This close anatomical continuity of the tissue with the muscle and Purkinje system suggested to Luscrue that electrical impulses might pass from the muscle to the tissue thus stimulating it to secrete. This discovery was soon published and was enthusiastically received by Bricthic. Could this be the tissue which was responsible for the secretion of the atheroma factor? Within a week both Luscrue and Bricthic had agreed that Bricthic should go to America and join forces with Luscrue into the investigation of this tissue.

The first thing these two workers did was to ascertain whether apes had a comparable tissue with that found in human bodies by Luscrue. They found, on careful dissection and subsequent histological examination that they did. Bricthic and Luscrue then operated on an ape and separated the secretory tissue from the heart wall, stimulated it electrically through electrodes placed in its substance and observed whether there was any change in the serum β lipoprotein level. It was seen to be reduced, the rate of reduction being related proportionally to the frequency of stimulation. They also found that if they removed the tissue, the ape was quite unable to exert its normal control over the β lipoprotein level. This and other work was good evidence in favour of the suggestion that this tissue was responsible for the secretion of atheroma factor.

The ape from which they had removed A.F.T. (atheroma factor tissue) was fed on a high cholesterol diet to determine whether it would develop atheroma or not. After three years they killed the ape and found, on autopsy, that the ape had in fact developed marked atheroma.

From other experiments Luscrue and Bricthic had found that if the apes were fed on a high animal fat diet (esters of polysaturated fat), that the β lipoprotein in the blood was maintained at a high level. From this Luscrue and Bricthic concluded that polysaturated fat either inhibited the atheroma factor or that polyunsaturaated fat was necessary for the synthesis of atheroma factor.

From subsequent experiments it has become evident that polyunsaturated fat is essential for the normal synthesis of the atheroma factor which appears to be a polypeptide.

The main points arising out of Luscrue's and Bricthic's work may be summarised as follows. Firstly, there is in the mediastinum of the ape, attached to the heart a tissue (A.F.T.) which secretes a polypeptide hormone, the atheroma factor, which causes a reduction in the β lipoprotein level almost certainly via some enzyme system. Secondly, the secretion of the atheroma factor relies upon an electrical stimulus from the heart such that the secretion of the A.F.T. is proportional to the heart frequency. Thirdly, polyunsaturated fat is vital for the normal synthesis of the atheroma factor.

Luscrue originally discovered the A.F.T. in the ape, so the question which remains is "are the findings of Bricthic and Luscrue about the A.F.T. in the ape applicable to man?" Work on this matter has only recently begun, but what information that is so far available suggests that it is applicable. If this is so, then it would explain the predominance of atheroma in the developed countries. People living in the developed countries have a low polyunsaturated fat intake which is inadequate for the synthesis of sufficient quantities of atheroma factor. In consequence the β lipoprotein levels are high, thus leading to a predominance of atheroma. Those people living in the so-called "under-developed" countries, however, having a higher polyunsaturated fat to polysaturated fat ratio in their diet, have normal synthesis of the atheroma factor leading to low β lipoprotein levels and low incidence of atheroma.

NURSING SECTION

Should Children Visit?

A recommendation has recently been issued to hospitals, instructing them that children should be allowed to visit their parents in hospital, and also their newborn brothers and sisters in maternity wards.

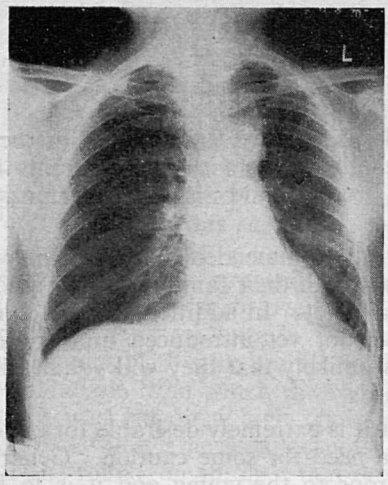
The move in this direction is to be commended, since it is known that children require to be in contact with their families just as much when they are well as when they are not. In addition, since a considerable number of hospitals have not yet introduced unrestricted visiting for their sick children, it is unlikely that they will voluntarily allow them to invade the adult wards.

However, whilst accepting that it is extremely desirable for children to visit their parents, there is a need for some caution. General wards can prove extremely dangerous to the young and it is to be hoped that the initial enthusiasm will not result in disaster. Since the onus for the introduction of this system will inevitably fall upon the Nursing Staffs, it may well be worth considering the hazards, of which there seem to be two outstanding.

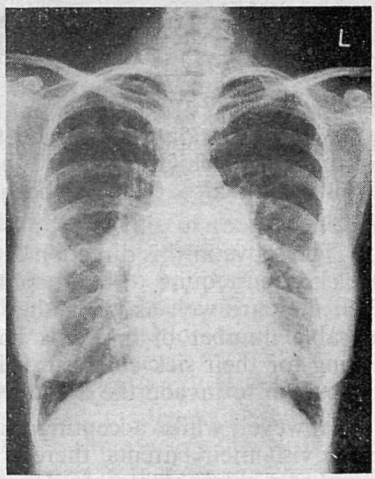
Firstly, there is the question of infection. Certain bacteria which cause only minimal disturbance in adults, might, if contacted by infants or toddlers, prove lethal. One might of course argue that infection is at a very high level in a children's ward. This is of course true, but it is also a fact that the facilities for dealing with it are far superior in most instances. This system will emphasise the need for ward sisters to be very much alive to who is actually visiting at any one time. She will also have to retain the right to use her discretion in this matter. If there are to be large numbers of children visiting it is going to prove difficult to prevent them wandering and if their nomadic instincts take them to a room where there is, for instance, a patient with tuberculosis, it could prove extremely dangerous. In addition to this, there is the infection which children may dispense. It is known that certain infectious diseases can prove extremely severe in certain circumstances and care will need to be exercised in this direction.

The second fact which one would stress is that of psychological trauma. Great care is taken nowadays to ensure that children are not admitted to adult wards, and this is one of the prime reasons. This is a hazard which is more likely to affact the slightly older child. Again it seems vigilance will be necessary on the part of senior nurses.

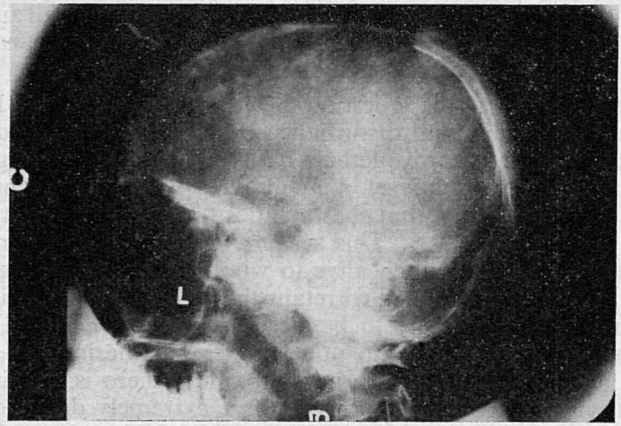
Of course, in many hospitals it has been the practice for some time for children to be allowed access, and with the generalised relaxation of visiting regulations the ward sisters have arranged with each individual for the visit to be at a mutually convenient time. Ideally, this is something which should be allowed to continue. If, however, the pendulum is permitted to swing too far in the opposite direction, one can envisage results which could prove far from happy.



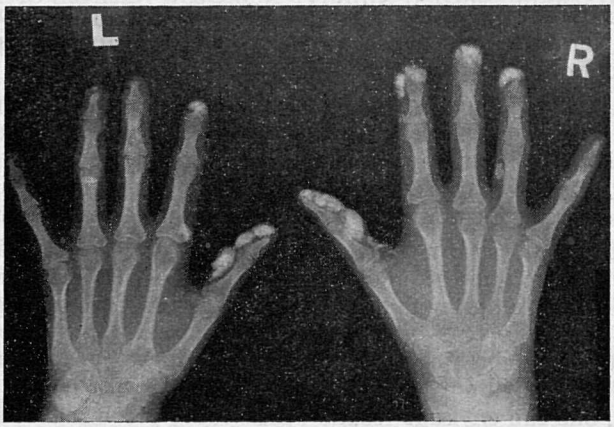
I



II

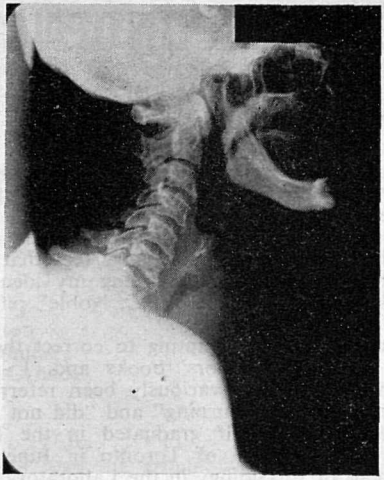


III



IV

V



Radiology Multiple Choice Questions

Tick those statements which you believe to be correct in relation to the above X-ray.

I. Left Lower Lobe Collapse.

(1) Consolidation of the lingula is present.
(2) The patient is likely to complain of heartburn when in bed.
(3) On clinical examination of the chest the heart appears enlarged.
(4) Occlusion of a main bronchus is likely.
(5) Aneurysm of the descending thoracic aorta is present.

II. Mitral Valve Disease.

(1) Pulmonary infundibular stenosis is present.
(2) Clinically a basal continuous machinery murmur is consistent with these appearances.
(3) The patient is likely to have suffered from rheumatic fever.
(4) Deep venous thrombosis of the legs is a likely precursor of this condition.
(5) There is radiological evidence of left-sided heart failure.

III. Paget's Disease of the Skull.

(1) Typical appearances of malignant erosions of the vault are present.
(2) The patient is likely to be over 40.
(3) Bilateral papilloedema is usually associated with this condition.
(4) Tibial bowing is a recognised complication of this condition.
(5) Haematemesis is a likely presenting symptom.

IV. Scleroderma of Hands.

(1) There is an associated painful swelling of the first metatarsophalangeal joints.
(2) This is a recognised complication of long-term dialysis for renal failure.
(3) An occupational history is relevant.
(4) A chest X-ray is likely to show basal fibrosis.
(5) The patient is likely to suffer from psoriasis.

V. Thyroid Enlargement with Tracheal Compression.

(1) The sacro-iliac joints are likely to be involved.
(2) The condition is likely to cause stridor.
(3) The patient may well present with cardiac failure.
(4) The patient's complaint is of a meat bone stuck in the throat.
(5) A sideropenic web is often a precursor of this condition.

Answers to these questions to be found on page 458.

CORRESPONDENCE

Who Discovered Insulin ?

SIR,—An English friend of mine, knowing of my close association with the scientific investigation following the discovery of Insulin, has kindly forwarded me the last copy of your *Gazette*.

Needless to say I am much interested, and in view of the publicity this will receive during the 50th Anniversary year, feel that I should finally, in my own defence, present some facts regarding my identity and activities at that time—you see I happen to be the "E. C. Noble" referred to in Dr. J. R. Henderson's article.

I have long since given up attempting to correct the mis-statements and misleading facts in the early authors' books and, I regret to say, some scientific papers. In these I have variously been referred to as "failing to appear", "being taken ill", "not returning" and "did not show up", etc.

Both Charles Best and myself graduated in the Physiology and Biochemistry course at the University of Toronto in June, 1921, and accepted work in the Department of Physiology in the Laboratory of Professor J. J. R. Macleod toward our M.A. degree. Shortly after we had begun, I well recall Professor Macleod bringing in and introducing us to Dr. Frederick Banting who, he said, wished to do some investigation into a process he had conceived for the extraction of Insulin. The Professor remarked that many scientists had attempted unsuccessfully to solve similar problems but he had added, "there is always a chance".

Best and myself were allocated to work with Banting for two months and to decide between ourselves in what manner we did so; to this end (contrary to most statements but corroborated by Banting in his Cameron Lecture in Edinburgh, 1928) we did toss a coin to see who would work first, and this happened to be Charles Best. It was also agreed that we should change over at the month's end; however, when this time arrived, Best had become proficient in assisting Dr. Banting in his surgical techniques so it was mutually agreed, in the best interest of the experiments that Best should continue to work out the full time with him.

As this discovery gradually indeed became a fact, Professor Macleod returned at once from Scotland, and since the work emanated from his laboratory insisted, and in my opinion rightly so, that certain basic aspects of the work should be repeated. These being confirmed he then outlined the associated major scientific problems that required urgent solution and to this end turned his whole laboratory staff and facilities over to the problem. To this group shortly afterwards, Macleod added Professor J. B. Collip, who was responsible for the purification of Insulin for its safe medicinal use in human beings.

It was agreed that all the initial papers should appear under the joint names of "Banting, Best, Collip, Macleod and Noble", and some ten to twelve of these are to be found in any Medical Library—unlikely activity for "the Man Who Never Was"—myself.

In Part I of Dr. Henderson's article, I am surprised that he has omitted the work of Rennie and Fraser, who unquestionably discovered and made Insulin from the codfish (Gadus Callurious). To further investigate this problem in light of Banting's discovery, Professor Macleod arranged for Dr. N. A. McCormick (deceased) and myself to spend the next summer at the Canadian Biological Station at St. Andrew's, New Brunswick, and later with the offshore and deep sea trawlers at Hawkesbury, Nova Scotia.

Since the codfish Islet tissue is separated from the zymogenous tissue and is situated at the tip of the gallbladder, it can be very easily removed and preserved in acid alcohol and later processed in the regular manner to produce a potent Insulin. Rennie and Fraser, unfortunately, failed to realise the potentialities of their discovery and their dogs died in what we now recognise as hypoglycemia.

Our work was published, if I remember correctly, in 1922 in two articles under the title "Insulin from fish," by McCormick and myself. No one, at or since that time, has seen fit to seriously investigate this work further or to recognise its significance as a valuable source of Insulin scientifically, and now, perhaps, more important, as an additional source of income to the off-shore fishermen.

I would be very grateful if you could find space in your next issue to publish the foregoing.

Yours sincerely,

E. CLARK NOBLE,
O.B.E., E.D., M.A.(Tor.), M.R.C.P.(Lond.).

C/o Mr. S. Heighington,
76, Rowanwood Avenue,
Toronto 5, Ontario, Canada.

SIR,—I was sorry to read the article "Who Discovered Insulin?" in your issue of 19th June, 1971, for it contains inaccurarcies which one would not expect to find in the journal of a great hospital.

I won't enter into an argument about who discovered insulin, for that fact is self evident. However, I must say that the references to Professor J. J. R. MacLeod are scurrilous bearing in mind the facts of the situation, his international reputation in carbohydrate metabolism and the experimental work which was required to develop Banting's discovery to the point where it could be put to the supreme test of applying it to the relief of human suffering. A review of the original articles might bring some understanding and perhaps indicate why the remarkable discovery was subsequently developed so rapidly that it was put to clinical use by January, 1922. Perhaps if Banting's predecessors referred to in the article had been fortunate enough to have associates such as Banting attracted and an experienced and knowledgeable physiologist such as Professor MacLeod one or other of them would have achieved success and brought the benefits to humanity years before.

A serious historian would not only consult all the records available but might think it useful to get in touch with some of those now living in Toronto who were intimately connected with the insulin story. I hasten to add that I was not. However, a small and really unimportant part could be straightened out very easily if your author would care to write to Dr. E. C. Noble, c/o Dr. E. J. Noble, 200 St. Clair Avenue West, Toronto 7, Ontario. You would also find a reference to this "apocryphal story" in Sir Frederick Banting's Cameron Lecture given at Edinburgh University in 1928.

I am,

Yours sincerely,

R. IAN MACDONALD, M.D.

Suite 312,
170 St. George Street,
Toronto 5, Ontario.

Short White Coats

SIR,—I do not wish to look like a waiter in a Wimpy Bar.
I beg the honour to remain your humble and obedient servant,

PAUL MARSHALL.

East Wing.

Of Cabbages and Weeds

SIR,—I am writing to you in regard to your article on health foods playing a dangerous and potentially lethal rôle. There is no one playing any more dangerous rôle than your G.P.s. The G.P. is a joke; they are overpaid, for all the good they do. I have been ill for five years with an upset stomach. I have seen about ten doctors and been given a lot of junk which I took, and I still have an upset stomach. I have cured people where your G.P. failed. When we go to a health food shop we are treated like human beings, and not like guinea pigs for your G.P. If you would ask people what they think of their G.P.s you would be surprised at the answers you'd get. Ask me about G.P.s and I will tell you to hell with your G.P. I know you will not print or answer this letter because it is the truth.

PETER SCOTT.

7, Woodfall Road,
London, N.4.

The Rites of the Unmarried

SIR,—

With reference the Bishop of Leicester,
I write to you now to suggest a
Change of approach to young girls who, perforce,
Consider their lives should include intercourse
To keep up with their fast-moving passions.

He believes that their priest, both in health and when ill,
Should be the same fellow who gives them the Pill;
He can cure their V.D. and their measles as well,
And so can advise them on Heaven and Hell,
He's the man who sets all the new fashions.

But the proof of the pudding, or so says the cook,
Should surely be found with the Bishop's own crook.
He just cannot state for the whole of the Church
That youth should be left in th'episcopal lurch,
He must lay down the size of their rations.

Yours faithfully,

U. N. TOWARD.
Churchwarden.

A Dog's Obeyed In Office

SIR,—Passim (14/8/71) fails to bring out the political importance of the Oz 28 saga, which is that for the second time in two years sentencing has been out of all proportion to the crime, but rather dictated by reasons of political expediency. It must be remembered that the Oz defendants were found not guilty of corrupting public morals or the morals of children, the most serious charges they faced, yet an unprecedented 15 months was imposed.

Previously was the example of the Garden House Hotel sentences, which certainly bore no comparison with the mild punishment meted out to the average "skin-head" after a bank holiday rampage. The point was that the Garden House riot was *politically* inspired. Also, Oz is first and foremost a *political* paper rather than a vehicle of pornography.

Sadly, we seem to be moving towards the concept of the political crime, long eschewed in Britain. Not, of course, by statute from the elected legislature but insidiously by this apparently new sentencing policy of the judiciary. It seems obvious that to leave this oppressive weapon of political motive, attracting long prison sentences, in the hands of a reactionary judiciary is far too dangerous in its possible consequences to be allowed in a signatory country of the European Commission on human rights.

Yours faithfully,

CHRISTOPHER J. BENNETT.

The East Wing,
Guy's Hospital.

Acute Infections of the Genito-Urinary Tract

SIR,—I was interested to read Mr. Latimer-Sayer's article on acute infections of the genito-urinary tract (31st July, 1971) and thought it provided a very good review of this important topic.

However, his list of three factors predisposing to progression of haematogenous infection omits any mention of the work of the late Professor De Navasquez (1956), which showed that the intravenous injection of Gram Negative organisms in experimental animals only produced pyelonephritis if there was previous renal scarring. Clinical observation amply confirms the significance of this work.

Vesico-ureteric reflux is rightly cited as a cause of urinary tract infection in children and the importance of this treatable and often undiagnosed anomaly can not be over-stressed. However, there was no mention of reflux as a result rather than a cause of urinary infection; this is quite commonly seen and corrects itself after a suitably prolonged course of chemotherapy.

Yours faithfully,

RICHARD SPICER

Reference: De Navasquez, S. (1956) J. Path. Bact., **71**, 27.

Faculty of Medicine,
Department of Morphology,
The University,
Highfield, Southampton, SO9 5NH.

"Women/Hair/Frippery/Hair/Women/Socialists"

SIR,—As a distinquished patient in the elegant wards of Guy's Hospital in ancient Southwark, I would like to register my impressions of the students of such a renowned hospital. I was admitted for a routine removal of a varicocoele and I was attended by hordes of long haired, scruffy youths and their female companions. I suffered the indignity of being looked after by two women. Surely, there are some aspects of medicine from which women should be excluded?

I was most upset by the appearance of medical students in general; some looked as if they were attending some hippy love-in, while others looked worse than some seedier members of society. All of them were scruffy with tubes, blood bottles, dirty needles and other such instruments of contamination hanging out of every conceivable pocket. Show me a man in pin-stripe trousers, morning coat and bowler hat and I will show you a good doctor. One wonders how these long-haired youths will behave when they are set loose on the public. I would hope that the appearance of the student should carry considerable weight during his final examinations.

Of course, I think there is a place for women in medicine, but certainly not on male wards and definitely not with handbags. These instruments of modern warfare are a definite nuisance on the wards. Professional women should wear suits as do professional men.

I hope that through you venerable columns I have been able to express an opinion which many of us hold but have been prevented from expressing by leftist editors.

I remain, etc.,

Yours faithfully,

E. D. BEAMISH, M.C.B.

"The Armoury",
Isle of Wight.

SPORT

SQUASH RACKETS

SINGLES COMPETITION

The Final was held on 6th April. As expected, the two finalists were Jerry Owen and Paul Calvert, both of whom had fairly easy paths to the final. In the first game there was very little between the two and Owen eventually won 10—8. Inspired by this, he quickly won the second game 9—4. The third game was the longest of the match. Calvert managed to find a much better length and, at one point, looked like taking the game. However, Owen's speed around the court eventually told and he won the game 9—7 and the match 3—0.

This win was thoroughly deserved. Throughout the season, Owen had shown consistently good form, the result of regular training and practice.

DOUBLES COMPETITION

The first Guy's Doubles Competition proved to be considerable success. 13 pairs entered and there were only 2 first round walk-overs!

The final, between Owen and Calvert (seeded 1) and Langdon and Evans (seeded 2) was held on 28th April. Langdon and Evans had the advantage of experience, being the only Guy's pair to have played much doubles. This experience showed and Evans and Langdon won an exciting match, 3—1. In the last game Paul Calvert nearly finished the match with one shot, when he not only hit the ball, but also his opponent's head. Fortunately, the President, Mr. Maynard, was on hand to supervise repairs, after which the match was finished.

SQUASH A.G.M.

This was held in the Gordon Museum, on 28th April. Mr. Maynard chaired the meeting which was attended by about 20 Club Members.

The following officers were elected for 1971/72.

President: Mr. J. D. Maynard, M.S., F.R.C.S.
Captain: E. J. Evans
Secretary: A. P. Edwards
Asst Sec.: C. Mackenzie
League Sec.: C. Gilbert

Among matters discussed, was the problem of court congestion during the squash season. It was decided that, as from September, 45 minute periods would be introduced. Players are asked to co-operate by:—

1. Only booking those courts they really intend to use.
2. Cancelling unwanted courts.
3. Only booking a court for one 45 minute period.

E. J. EVANS.

CRICKET TOUR, 1971

Arrangements for the tour were finalised about four hours before the first match and after the scorebook had been recovered from somewhere in the heart of London, the team headed for a pub in Basingstoke. Most of the 11 reached this objective which probably explains our batting performance after we were inserted on a hard wicket by a strong Hampshire 2nd XI side. Langdon lost the ball in the second over (one way of getting rid of the shine!) but despite this, Basingstoke managed to take wickets with an old ball and Guy's were all out for 123, the most notable shot of the innings being a straight six by Ogle off the "Oh-so-professional" Basingstoke skipper. The bowling and fielding was sloppy generally and they knocked off the runs for 4 wickets.

Some of the team headed home, and O'Keefe went off after some old flame in Basingstoke, and the rest headed for Thatchings via one or two pleasant inns. The girls, of course, were waiting, and after discothequing at Bognor till 1.30 a.m. and a swim at 2.00 a.m. the scene was set for another interesting day's cricket at Pagham. We were put in again and with a good 50 from Clifford-Jones, 43 from Evans (feeling the effects of the previous night!) and some lusty blows from Burns we were able to set them 169. Apart from their no. 4, who made 99, none of their batsmen produced many strokes and a draw resulted with their needing 6 runs and our needing 1 wicket in the last over (*Goodhart took 6 for 67*)—however we were robbed by two bad decisions by their umpire in the final over.

The same strong side took the field against Bognor who were dismissed for 97, *Goodhart and O'Keefe taking 5 wickets apiece.* After a good opening stand things were going well, but with the score at 97 for 4 Evans, Burns (to a fantastic diving catch on the boundary) and Rees were all out, and when Fitton hit the winning boundary we had won by only 3 wickets. The shot of the match was a six over extra-cover by Clifford-Jones. Since this match finished early, we played a 15 over match, which ended with both sides on 94 but I maintain we won since we had lost less wickets.

Several of the team had to return home after this match, which was a great pity. It would be ideal to get 11 or 12 players down for the whole tour—this would be more fun for all concerned and produce better teams.

We only had 10 men at Worthing since Davies was unable to make the tour and we welcomed those three 2nd X1 stalwarts Skinner, Rigg and Ryan, who did us proud in the match. Worthing declared at 162 for 7. (Ryan 3 for 13) and after Gillham was out in the first over Langdon and Holland put on 99 and we looked to be cruising to victory. However, Langdon played a bad shot (unplayable ball!) and was out for 65, Holland for 38, and once Burns had done his usual trick of being caught on the boundary at a crucial stage, Ramsey and Skinner took us to a narrow victory by 3 wickets in the last over.

The events of Tuesday and Wednesday are not for recording, and on Thursday we set off for Cuckfield. The match was rained off at 12.15 and the pub welcomed us. It was decided to play a 30-over match, starting at 4 p.m. Until then most of the teams participated in a 10-a-side catching match whilst Winter lay horizontally on the square. In the match they made 116 (Langdon 3 for 12) and we were all out for 84 (Holland 27). Most of the team returned to Thatchings for a few more days of sun, sea, etc., which eventually brought to conclusion a very successful and enjoyable tour.

Answers to X-ray Multiple Choice Questions

I. Left Lower Lobe Collapse.

(1) INCORRECT—Lingular consolidation shows as an opacity in the mid and lower zone adjacent to the heart with loss of definition of the cardiac border in this area.

(2) INCORRECT—A hiatus hernia seen through the heart shadow is roughly spherical with a convex upper border and it does not extend high in the mediastinum. A fluid level may be seen within it.

(3) CORRECT—A collapse of the left lower lobe may couse the heart to move to the left and this is likely to be interpreted clinically as a cardiac enlargement.

(4) CORRECT—Left lower lobe bronchial occlusion is present with collapse of that lobe resulting in deviation of the heart to the left and some elevation of the left hemi-diaphragm. The collapsed lobe is seen as a triangular shadow behind the heart with a very well-defined lateral border. In addition there are fewer vessels in the left lung field because the upper lobe blood vessels are spread out consequent upon a compensatory emphysema of that lobe.

(5) INCORRECT—The edge of the opacity seen through the heart shadow is not continuous with the aortic knuckle. Also the lateral border of the opacity is seen to extend downwards and laterally below the dome of the left hemi-diaphragm whereas the lateral border of an aneurysm would be directed medially at this point.

II. Mitral Valve Disease.

(1) INCORRECT—Dilatation of the main pulmonary artery does not occur in pulmonary infundibular stenosis and there is no oligaemia of the lung fields which may be present in the latter condition.

(2) INCORRECT—A persistent ductus arteriosis will produce pulmonary plethora; that is dilation of the pulmonary arteries throughout the whole of their course including their small peripheral branches. These appearances are absent in this X-ray.

(3) CORRECT—The patient has rheumatic mitral valve disease.

(4) INCORRECT—A massive pulmonary embolus may cause dilatation of the main pulmonary artery or one of its central branches proximal to the embolus but there will be an associated oligaemia distal to that point. Multiple small pulmonary emboli can cause pulmonary arterial hypertension with dilatation of the central pulmonary arteries bilaterally but there will be an associated peripheral oligaemia.

(5) CORRECT—The mitral valve disease is indicated by the presence of an enlarged left atrium which is seen as a roughly spherical opacity within the heart shadow and giving a double outline to the right heart border. The left atrial appendage is seen as a prominence of the left heart border inferior to the main pulmonary artery. In this case there is pulmonary venous hypertension resulting in a diversion of blood to the upper lobes with consequent engorgement of the upper lobe veins. In addition, the venous hypertension has caused interstitial pulmonary oedema as shown by the short horizontal septal lines (Kerley B lines), at both bases. Pulmonary arterial hypertension has occurred secondary to the venous hypertension and it is shown as dilatation of the main pulmonary artery and its immediate left and right branches.

III. Paget's Disease of the Skull.

(1) INCORRECT—Where the vault is seen tangentially the inner table is intact and there is a roughly diffuse thinning of the bone affecting mainly the middle and outer tables. Malignant deposits tend to be more discrete and would be likely to involve the inner table if the skull were so extensively infiltrated.

(2) CORRECT—Paget's disease is typically a condition of late middle and old age. The bones are widened and the trabecular pattern is coarsened as seen in the mandible and occiput. A complication in the skull is osteoporosis circumscripta which is well seen in the frontal, temporal and occipital regions.

(3) INCORRECT—Raised intracranial pressure is not likely to result from Paget's disease.

(4) CORRECT—There is often a generalised involvement of the skeleton and the tibiae thus weakened may become bowed.

(5) INCORRECT—Secondary deposits from a carcinoma of the stomach would not give these appearances—(as stated in 1).

IV. Scheroderma of the Hands.

(1) INCORRECT—Loss of the terminal phalangeal tufts does not occur in gout and juxta-articular erosions are often seen in the finger joints.

(2) INCORRECT—In renal glomerular osteodystrophy terminal tuft erosions occur but there are also cortical erosions on the radial aspects of the phalanges and soft tissue calcification mainly in the arteries. These changes are due to secondary hyperparathyroidism.

(3) INCORRECT—Raynaud's disease, resulting from working with vibrating tools, will cause loss of terminal phalangeal tufts due to ischaemia but soft tissue calcification does not occur.

(4) CORRECT—Extensive digital soft tissue and terminal phalangeal loss is present. This, together with the marked soft tissue calcification, is typical of scheroderma.

(5) INCORRECT—In psoriasis distal phalangeal tuft loss can occur but there is no soft tissue calcification.

V. Thyroid Enlargement with Tracheal Compression.

(1) INCORRECT There is no evidence of ankylosing spondylitis, i.e. the anterior surfaces of the vertebral bodies have not lost their concavity, the inter facetal joints are unfused and there is no obvious para spinal ligamentous calcification or ossification. The changes present are of spondylosis with anterior osteophyte formation.

(2) CORRECT—The enlarged thyroid is causing marked antero posterior tracheal compression likely to result in stridor.

(3) CORRECT—The goitre may be toxic and in the elderly thyrotoxicosis may well present as cardiac failure.

(4) INCORRECT—The opacities lying anterior to the bodies of C.5, 6 and 7 are the calcifications which commonly occur in a nodular goitre. In addition, the calcified posterior aspects of the thyroid and cricoid cartilages overly the oesophagus at the C.5/6 level. N.B.—Gross anterior osteophyte formation due to cervical spondylosis may rarely cause dysphagia but this is not relevant in this patient.

(5) INCORRECT—There is no thickening or irregularity of the soft tissues in the post cricoid region to suggest a carcinoma of the hypo-pharynx.

HOSPITAL INFORMATION

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited from graduates with immunological experience and an interest in immunological methods of investigating and treating disease, for the post of **Lecturer** (full-time) in the Department of Medicine. A medical qualification is not essential. Salary in the range £2,450—£3,926 (or £2,454—£3,417+£100 London Allowance non-clinical scale), according to qualifications and experience, with superannuation. Forms of application obtainable from the Dean's Office, Guy's Hospital Medical School, London Bridge, SE1 9RT. Closing date **8th September, 1971.**

GUY'S HOSPITAL MEDICAL SCHOOL
Department of Anaesthetics

Research Assistant (first year Registrar) required for one year from October 1971. The successful candidate will assist in work on the control of post operative pyrexia following open heart surgery. Opportunity to help in Cardio-Pulmonary Unit and some clinical work will be included. Applicants should visit and obtain further details from Dr. R. J. Vale, Department of Anesthetics, Guy's Hospital. Application forms are obtainable from the Dean, Guy's Hospital Medical School. Closing date for application **19th September, 1971.**

THE BOARD OF GOVERNORS OF GUY'S HOSPITAL

Invite applications for the appointment of **Senior House Officer** in Clinical Pathology at St. Olave's hospital to commence on 1st October, 1971 until 30th September, 1972. The post offers good general training in pathology. Further information may be obtained from Dr. Fullerton of the group laboratory at St. Olave's Hospital. (Tel. 237 4311). Application forms are obtainable from and should be returned to the Superintendent, Guy's Hospital, London, S.E.1, not later than **10th September, 1971.**

THE BOARD OF GOVERNORS OF GUY'S HOSPITAL

Invite applications for the appointment of a **Senior House Officer/Registrar** in the Clinical Pathology Department to commence on 1st October, 1971 until 30th September, 1972 in the first instance. The post provides a 3 year training programme covering microbiology, clinical chemistry, haematology and morbid anatomy and is recognised for training for the M.R.C. (Path). Appointment will be at S.H.O. level in the first place with promotion to Registrar. Forms of application are obtainable from and should be returned to the Superintendent's Office, Guy's Hospital, London, S.E.1, not later than **10th September, 1971.** Candidates are invited to visit the various departments.

GUY'S HOSPITAL, BOARD OF GOVERNORS

Applications are invited for the appointment of **Junior Surgical Registrar** (Senior House Officer Grade) for the period 1st October, 1971 to 30th September, 1972. Forms of application are obtainable from, and should be returned to, the Superintendent, Guy's Hospital, London, S.E.1, not later than **3rd September, 1971.**

GUY'S HOSPITAL, BOARD OF GOVERNORS

Applications are invited for the appointment of **Locum Registrar** in Orthopaedic Surgery from 1st November, 1971, for a period of five months. Application forms are obtainable from and should be returned to the Superintendent, Guy's Hospital, London, S.E.1, not later than **3rd September, 1971.**

GUY'S HOSPITAL, BOARD OF GOVERNORS

Applications are invited for the appointment of **Locum Registrar** in the Accident and Orthopaedic Department and the Plastic Surgery Department of the Guy's Group of Hospitals for the period 15th September, to 2nd October, 1971 inclusive. Applications with the names of two referees, or enclosing two recent testimonials, should be submitted to the Superintendent, Guy's Hospital, London, S.E.1, within one week.

CHANGES OF ADDRESS

Dr. P. Banks, Falconwood House, Florance Lane, Groombridge, Sussex.

S. N. Cripps, Esq., B.D.S., 8, Oak Street, Somerset West, Capetown, R.S.A.

Dr. Rosemary Hall, 12, Grange Road, Lewes, Sussex. Tel: Lewes 5661.

Mr. and Mrs. J. D. Haworth, 104, Brighton Road, Banstead, Surrey. Tel: Burgh Heath 54737.

Shaun and Anne Brown to 31, Balmossie Street North, Monifieth, Angus, from 13th September.

Sir Charles and Lady Symonds, 180, Chiltern Court, Baker Street, London N.W.1, from 16th September, 1971.

Permanent London address from 24th August, 1971: Dr. and Mrs. Philip Helliwell, 31, Merrick Square, London, SE1 4JB. Tel: 407 3774.

Dr. and Mrs. J. E. Davies, 41 College Court, Hill Street, Haverfordwest. Tel: 3693.

BIRTHS

PEACE—On 3rd July, 1971 to Jane and Peter Peace, a daughter, Katherine Amanda Lucy.

TAFT—On 10th August, 1971 at Epsom District Hospital, Surrey, to Christine (née Lane) and George, a beautiful little daughter, Charlotte Caroline.

DEATH

CAMPION—On 14th August, 1971 in Brisbane, Australia. Dr. Rowland Burnell Campion, of Alexandra, Egypt, and Famagusta, Cyprus, Guy's Hospital, Old Contemptible, Captain, R.A.M.C., 2nd World War, friend and counsellor to so many, beloved husband of Kathleen Shelley, passed into the presence of his Lord and Saviour, aged 83.

GUY'S HOSPITAL GAZETTE

EDITOR A. M. TURNER
NEWS EDITORS C. G. CHINERY and D. I. F. KELLEHER
SPORTS CORRESPONDENT A. M. ROYSTON
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TEN PENCE VOLUME 85 NUMBER 2170

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Make Yourself Scabs

Over this past week the British Association met in Swansea for its annual meeting. At the risk of making two generalisations it is fair to say that one of the most important contemporary issues, never debated sufficiently, is the responsibility of scientists involved in producing deadly war weapons of increasing effectiveness. Yet again the discussion was inadequate.

The defense of these research endeavours is a mixture of Irish logic and arguments that pirouette in circles. First there is the view that everybody else is doing it so we had better not fall behind. Then there is the tale that since the atomic bomb was invented the grosser powers have been conspicuously peaceful. Following closely is a bag of assorted nuts, displaying amongst other solemn pieces of wisdom that the person who pays the piper and manufacturer of C.S. gas calls the tune, therefore scientists need consider themselves completely the servants of society with no analysis of their own actions. Also in that bag is the chauvinistic doctrine of those who consider that it is treachery to undermine the security of this civilised country; that those wet willies who ask pathologists who breed and package invasive and killing strains of bacteria to consider the absurdity of their work are betraying the enlightened.

There is lastly the argument that good always comes of wars. That wonderful radar was developed in response to a military need. Appended to that is the delightful thesis that it is impossible to blame any one person in the chain of scientists from Newton, Curie and Rutherford to those who produced the atomic bomb, so nobody is responsible. The people who quest for perfect destructive weapons are clearly responsible.

The impulsive fear of change induces us to adopt rigid attitudes in favour of our armies. Equipping national forces with power suffi-

cient to destroy another whole nation has not had a pacifist effect. It has merely removed the theatre of war, if such behavour can be likened to an exercise of education and entertainment, to small countries far from the real opposing nations, where the fight is purported to be between small powers and not their big brothers. The excuse that scientists with their secret powers must do as they are told, unquestioningly, curiously disengages the scientist from his society. Others are allowed a choice and consideration of these matters but those with the knowledge are not. Those who finally have to take the decision to use their special knowledge in an especially vindictive manner are not expected to think.

The treachery involved is a more serious accusation. It is one that implies all good will be destroyed by those who have not the strength of personality to protect the cherished arts, sciences and manners of the West. It is, however, a shaky reason and a questionable good that surrounds itself with capsules of lethal germs and bombs for protection; that allows only those to prosper who are beneath its jurisdiction; that kills its enemies at a distance and tortures those near at hand.

Many say there is little difference between being killed by a fulminating disease and being scalded to death by a pot full of boiling pitch. How true, the result is just the same. Knowledge will always be abused so long as we agree that there is no point in blaming those who further our killing techniques.

Last week, J. L. Lewis and R. M. Darling retired from their pioneering as News Editors for the *Gazette*. They have forsaken journalism to pursue further their careers in medicine. We welcome in their place C. G. Chinery and D. I. F. Kelleher.

NEWS IN BRIEF

The questions are reproduced exactly as asked in the survey, the format has been re-arranged for clarity.

It was decided to make a distinction between students doing their first two firms and more senior students (i.e. Junior and Senior students) to establish any difference in attitude between them. A reasonable difference appears to exist, so the results are shown separately.

Altogether 16 firms took part, and a total of 171 students expressed their views. The results are expressed as total number of replies and percentages, but as not all students answered all the questions, the percentages usually fall short of 100.

Students were also asked on the questionnaire to express their own comments.

TABLE OF RESULTS OF SURVEY.

		Junior Students		Senior Students	
		Total	%	Total	%
Would you be prepared to:—					
Wear white coats	Yes	61	**93**	94	**87**
	No	2	**3**	14	**13**
Pay for coats	Yes	54	**86**	68	**63**
	No	8	**13**	36	**33**
Pay for laundry if Guy's organise it (approx. 5p)	Yes	49	**78**	67	**62**
	No	13	**21**	37	**34**
Launder your own	Yes	22	**35**	26	**24**
	No	40	**64**	77	**71**
Have a restriction on the places coats are worn	Yes	11	**17**	11	**10**
	No	50	**79**	90	**83**
Should students have means of identity	Name badge	55	**87**	90	**83**
	mark	4	**6**	0	**0**
	None	5	**8**	16	**15**
Should Local Education Authorities pay for everything	Yes	56	**89**	69	**64**
	No	7	**11**	30	**28**
Length of coat	Jacket	2	**3**	4	**4**
	¾	45	**71**	55	**51**
	Full	15	**24**	45	**42**

The vast majority of students would be prepared to wear a white coat, although some of the senior students were against it only because they were not prepared to pay out when they had nearly finished the course.

One student put the point "prepared to" does not mean "wishes to", a male student expressed the opinion that "we should be provided with five three-piece suits on the N.H.S.", but the last word goes to a woman (of course) who wrote "females are in favour of white coats, owing to the fact that handbags can be abolished."

Senior students were noticeably more reluctant to part with any cash, either initially or for laundry. However, they expected less than the junior students of the Local Education Authorities, though a majority of both student types thought the L.E.A. should finance the scheme.

The question of finance aroused the most comments, most frequent of which was that, although prepared to pay if really necessary, students felt it should be paid either because "we perform N.H.S. functions", or "it is part of our expenses" or "Guy's can afford it".

Laundering our own coats was not at all popular, the thought of washing, starching and ironing two coats a week as part of learning medicine did not appeal to many.

Most students felt there should be no restrictions on the places coats are worn, as "it would be a nuisance having to keep swapping coat for jacket", however some thought this would be acceptable if adequate changing facilities were available. Few would disagree that they should "not be worn on London Bridge Station or Bermondsey Street".

There was a very strong reaction to the question of a means of identity, name badges were much in favour, with the poignant comment "that this would reduce the faceless masses at Guy's to a minimum, and allow one's identity to be kept".

The length of coat has already aroused considerable comment, a further one was "Ice Cream coats are out, out, out". Full or three-quarter length appears to be in.

The returns of this survey were very good, considering the inherent difficulties in any survey, particularly at this time of year with many students away on holiday or elective posts.

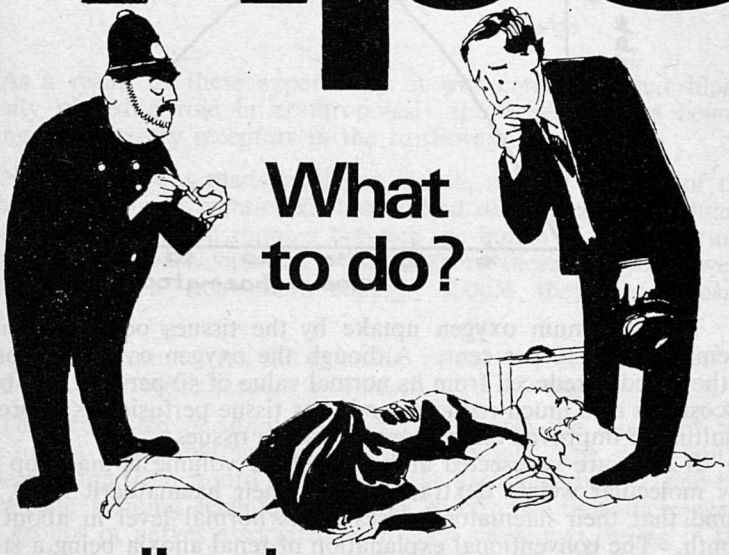
Before this survey was conducted, it was felt that most students were in favour of white coats for reasons already expressed, and this has been confirmed. The main point was to establish how strong this conviction was, that is, were students prepared to pay? The answer is that they are.

Our brethren in the School of Dentistry already enjoy these facilities free of charge, as do laboratory technicians and sundry others. Medical Students however are prepared to pay for this privilege.

On a more practical point, it was suggested several times that there should be a central pool of coats, rather than an individual service, dirty coats being returned and clean ones issued, presumably with a charge, two or three basic sizes being kept in stock.

I can only repeat perhaps the most relevant comment expressed "get it all moving".

mps



medical protection society est 1892

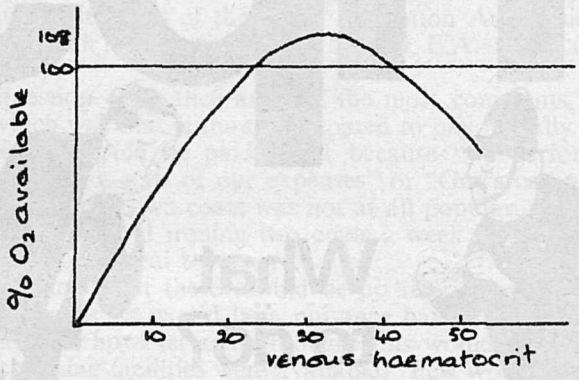
Unlimited legal aid and indemnity against professional hazards throughout the world
(except U.S.A.)

Secretary Dr. H. A. Constable. Head Office
50 Hallam Street, London, W1N 6DE. Tel: 01-580 9241
or Regional Secretary Dr. P. G. T. Ford
Regional Office: 30 Park Square, Leeds 1. Tel: 0532 42115-6

Viscosity Receptors in the Aortic Arch

R. C. Saumarez

It has been established that the relationship between oxygen available to the tissues and the haematocrit follows the curve shown below:

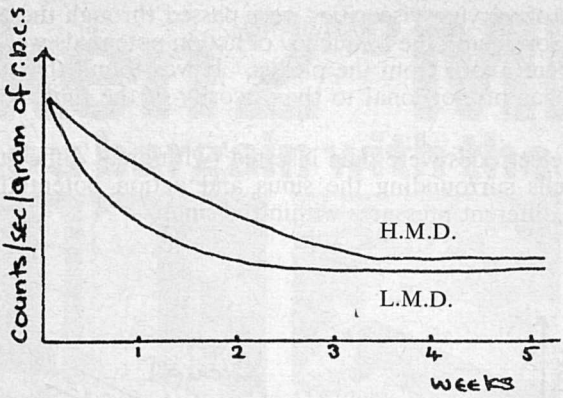


The maximum oxygen uptake by the tissues occurs when the haematocrit is 30 per cent. Although the oxygen carrying capacity of the blood is reduced from its normal value of 40 per cent, the blood viscosity is also much reduced, and thus tissue perfusion is improved, resulting in improved oxygen uptake by the tissues.

If dogs are venesected and their blood volume is made up with low molecular weight dextrans so that their haematocrit is 30, it is found that their haematocrit rises to its normal level in about one month. The conventional explanation of renal anoxia being a stimulus to erythropoietin release, and hence erythropoiesis, is clearly inadequate to account for this phenomenon, and other mechanisms must be looked for.

(*From this point the account becomes fictitious)

In an early experiment two groups of dogs were venesected and their plasma volumes were made with, in one group low molecular weight dextran solution, and in the other group, high molecular weight dextran solution which is more viscous. They were also injected intravenously with ^{51}Cr labelled red cells, so that alterations in their red cell mass could be followed accurately, since haematocrit is a function of both red cell mass and plasma volume. An experiment was also performed to determine the rate of lysis of the labelled red cells, so that the absolute rather than the relative change in red cell mass could be determined. It was found that the group of dogs which had had their plasma volume made up with low molecular weight dextrans increased their red cell mass more quickly than those which had high molecular weight dextrans.

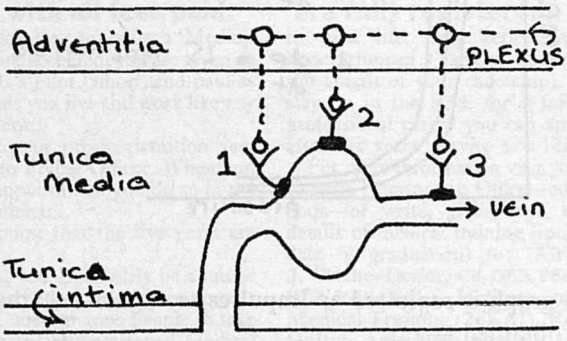


As a result of these experiments it was concluded that blood viscosity played a role in erythropoiesis and a search was begun, looking for viscosity receptors in the cardiovascular system.

No progress was made with this search, until a member of the anatomy department mentioned that he had discovered small shunts in the arch of the aorta running between the lumen of the aorta and the veins of the vasa vasorum. Furthermore these structures were associated with a rich nerve supply. Could they be viscosity receptors?

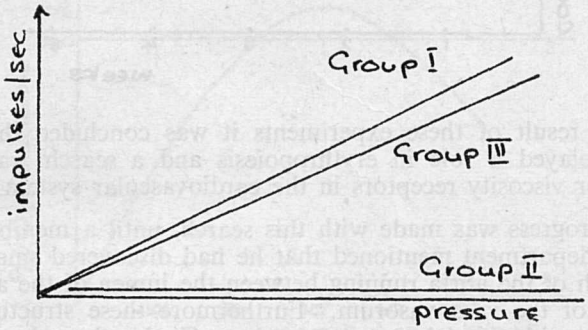
On close examination the existence of these structures was confirmed and their structure was elucidated.

They consisted of small vessels running from the lumen of the aorta into a distensible sinus in the tunica media. The sinus had a venule running from it into the veins of the vasa vasorum. Using the appropriate staining techniques, it was discovered that there were three groups of nerves associated with each sinus, two ending in the sinus itself and one, some distance along the venule. These synapsed and formed a plexus in the adventitia of the artery. Afferent fibres from this plexus passed into the vagus.

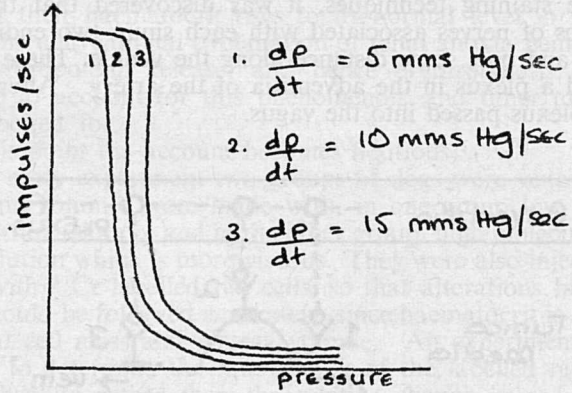


Fluids of varying viscosities were passed through these structures in isolated aortae and the frequency of action potentials were measured in the afferent axons from the plexus. It was found that the impulse frequency was proportional to the viscosity of the fluid perfusing the shunts.

Microelectrodes were then inserted (with great difficulty) into the receptor cells surrounding the sinus and action potentials were recorded for different pressures within the sinus:—



Recordings were made from the group II receptors whilst the pressure inside the sinus was being changed, and different families of curves were obtained for different rates of change of pressure.



If this graph is replotted as Impulses/sec against $\frac{1}{p^4}$ the following curves are obtained:—

Taken 2ND MB?

Strike a bargain with the RAF

You get

–£1697 a year in your last three years as a medical student; with all fees paid.

This is how it works. You apply for a 'Medical Cadetship'. If you are accepted, you are given an RAF commission as a Pilot Officer, and paid as such. Apart from this you live and work like any other medical student.

When you start your pre-Registration year you are promoted to Flying Officer. When you take up your first appointment you do so in the rank of Flight Lieutenant.

It is from this point that the five years are reckoned.

In RAF practice, you'd probably be a junior Medical Officer at a Station; one of two doctors with, between you, 2000 to 3000 people to take care of, and your own fully equipped Medical Centre with secretarial as well as nursing staff. Part of your time you might well spend abroad.

At the end of five years, if you want to return

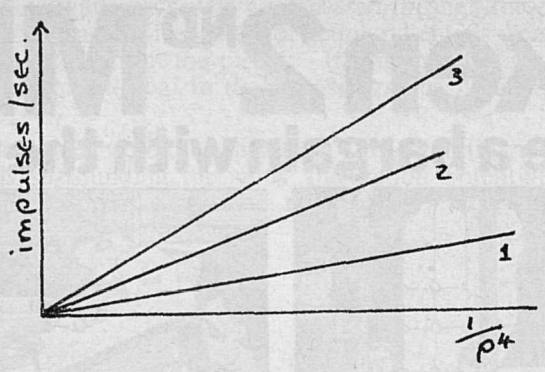
In return

– you practise for 5 years in the RAF as soon as you are fully registered.

to civil life, you 'retire' with a tax-free honorarium of £1400 to £2600 (depending on the length of your cadetship). If you want to stay on in the RAF for a full and satisfying professional career you can apply at any time after two years' service as a Flight Lieutenant.

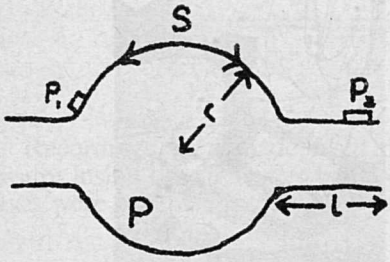
For more information visit your nearest RAF Careers Information Office—address in 'phone book—or write, giving age, nationality, and details of medical training (including expected date of graduation) to: **Air Vice-Marshal J. Clarke-Taylor, CB, OBE, BSc, MB, ChB, DPH, DIH, RAF (Ret'd), Institute of Health and Medical Training (26KAI), Royal Air Force, Halton, Aylesbury, Bucks.**

Royal Air Force



Thus groups I and III receptors respond to pressure in the sinus venule respectively whilst from the group II receptors, the impulse frequency is proportional to $\frac{1}{p^4} \cdot \frac{dp}{dt}$.

These results may be interpreted in terms of a mathematical model:—



r = radius of sinus

S = surface tension

P = pressure in sinus

l = length between sinus and receptor 3

Now $p = \frac{2S}{r}$

Therefore $\frac{dp}{dt} = -\frac{2S}{r^2} \cdot \frac{dr}{dt}$,

and the volume of the sinus is $v = \frac{4}{3} \frac{22}{7} r^3$

Therefore $\frac{dv}{dt} = 4. \frac{22}{7} r^2 \frac{dr}{dt}$

but $\frac{dr}{dt} = \frac{-r^2}{2S} \cdot \frac{dp}{dt}$

Therefore $\frac{dv}{dt} = -2. \frac{22}{7} r^4 \cdot \frac{dp}{dt}$

but $p^4 = \frac{16\ S^4}{r^4}$

Therefore $\frac{dv}{dt} = -32.\ \frac{22}{7}\ \frac{r^3}{p^4}\ \frac{dp}{dt}$

Hence when receptor II discharges at a frequency of $\frac{1}{p^4}\ \frac{dp}{dt}$ it is discharging at a rate directly proportional to $\frac{dv}{dt}$.

Assuming laminar blood flow along the venule n = viscosity. and $\frac{dv}{dt} = \dot{v}$

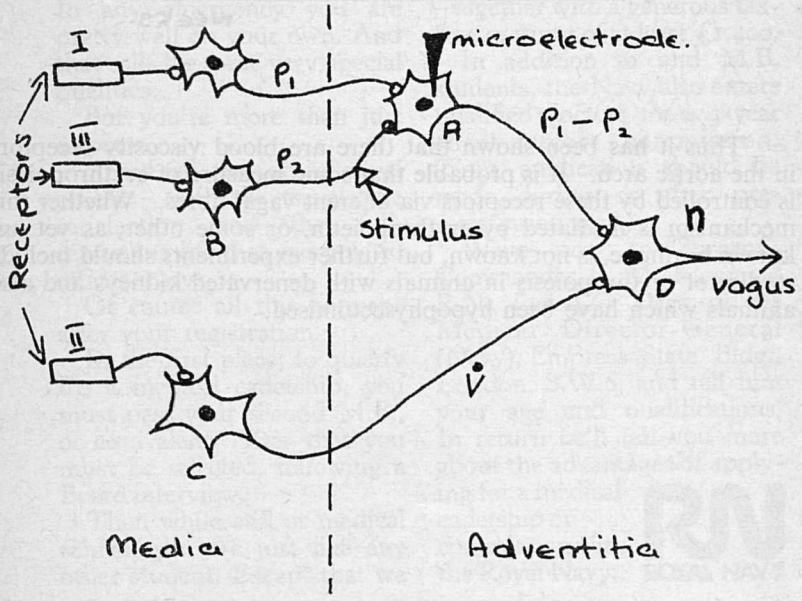
$\frac{dv}{dt}$ is proportional to $\frac{1}{n}\ \frac{dp}{dl}$

or more simply $\frac{dv}{dt}$ is proportional to $\frac{p_1 - p_2}{n}$ since 1 is constant.

And so n is proportional to $\frac{p_1 - p_2}{\dot{v}}$.

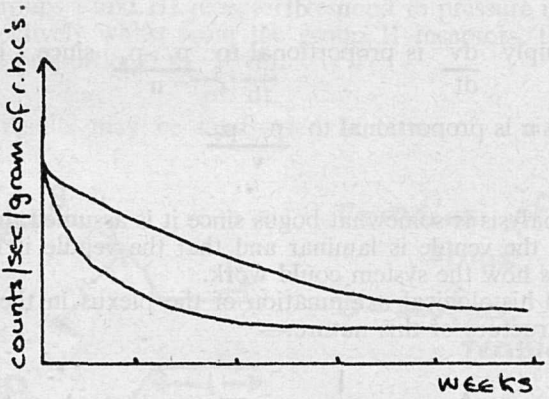
This analysis is somewhat bogus since it is assumed that the flow of blood in the venule is laminar and that the venule is non-elastic, but is shows how the system could work.

Careful histological examination of the plexus in the adventitia showed a structure of this nature:—



A microelectrode was inserted into cell A and the axon from cell B impinging on it was stimulated electrically. It was found that impulses from cell B created an inhibitory post synaptic potential on cell A, and that the rate of discharge of cell A was proportional to $p_1 - p_2$. Similarly cell C created an inhibiting post synaptic potential on cell D which thus discharged at a frequency proportional to n.

Two groups of dogs, one of which was vagotomised, were venesected and had their plasma volume made up with dextran 40. The change in red cell mass was far greater in the control group of dogs, indicating that there is a vagal component in erythropoiesis.



Thus it has been shown that there are blood viscosity receptors in the aortic arch. It is probable that some measure of erythropoiesis is controlled by these receptors via afferent vagal fibres. Whether this mechanism is mediated by erythropoietin, or some other, as yet unknown hormone, is not known, but further experiments should include studies of erythropoiesis in animals with denervated kidneys and also animals which have been hypophysectomised.

The Navy is offering twenty-five medical cadetships this year. What are your chances?

Having passed your 2nd M.B., it all depends on you.

For our requirements are not simply your medical qualifications – but also the way in which your personal qualities match up to the demands of being a medical officer in the Royal Navy.

You see, as the only doctor on board, the entire medical responsibility for the ship's officers and men is yours. You might for example be somewhere in the Arctic or deep down in a nuclear submarine. In any emergency you are pretty well on your own. And that calls for some very special qualities.

But you're more than just a doctor.

Above all you are a naval officer – with the travel, the satisfaction and the full, rewarding life that every naval officer enjoys.

Of course all this happens after your registration.

In the first place, to qualify for a medical cadetship, you must pass your second M.B., or equivalent. After that you must be selected, following a Board interview.

Then while still at medical school, you are just like any other student. Except that we pay your fees and give you a guaranteed salary of £1,697 a year in the rank of Surgeon Sub-Lieutenant.

When you qualify you can spend your pre-registration year either at your hospital or one of ours.

After which we promote you to Surgeon Lieutenant, your pay goes up to £3,249 a year and you then begin your short-career commission with us for five years. When you leave us you'll take a lot of useful experience with you – together with a generous tax-free gratuity of at least £1,400.

In addition to 2nd M.B. students, the Navy also enters qualified doctors for a 5-year short-career commission. (Your application should be made during or after pre-registration year.)

Write now to Surgeon-Commander F. M. Kinsman, R.N., (26 AZ), Dept. of the Medical Director-General (Navy), Empress State Bldg., London, S.W.6, and tell him your age and qualifications. In return he'll tell you more about the advantages of applying for a medical cadetship or commission with the Royal Navy.

RN ROYAL NAVY

Triple Helices and Metabolism

P. S. Sebel

Work was being carried out into the structure and functions of the fatty tissue surrounding the heart. In one section of adipose tissue from the superior mediastinum a histologist noticed an aggregation of cells.

Similar sections were examined using the electron microscope and it was found that the cells showed few remarkable characteristics except they had large nuclei relative to their size and contained above average numbers of mitochondria.

These studies were initially confined to rhesus monkeys but were extended to other primates and then to vertebrates. The histological/anatomical findings may be summarised as follows:—

In the superior mediastinum in all vertebrates there are two or three aggregations of cells contained in the adipose tissue. The amount of this tissue is up to $\frac{1}{2}$ mg in larger animals, less in smaller ones and appears specific to vertebrates. The aggregations are normally situated close to the walls of the superior vena cava and blood flow has been demonstrated in the live animal from exceedingly small branches of the coronary arteries and venous drainage directly into the superior vena cava. These tissue aggregations were called X organs and had no obvious function. They had no nerve supply as far as could be determined.

It was initially thought the the X organs had some endocrine function. If they were removed from an animal, after a few days most unusual symptoms occurred: there was gradual loss of function, blood pressure fell slowly, muscle wasted, gut secretion decreased, loss of co-ordination and after a short while death followed. If the X organ was transplanted to another part of the body and a good vascular supply re-established then in some cases the animal showed no ill-effects, in other cases it died, following the symptoms described above.

No secretions into the blood were demonstrable. After extensive biochemical research, evidence accumulated that there were raised quantities of ribonucleic and deoxyribonucleic acid in the blood leaving the X organ.

Further studies using electron microscopy demonstrated an unusual vascular system. The capillary beds were surrounded by the cells of the X organ in fairly specific patterns.

There seemed to be two types of capillary circulation, one a direct through flow and the other to the X cells and away from them, these latter capillaries seemed discontinuous and it appeared that plasma possibly travelled through the cells or at least small quantities did. This might explain why transplants lead to death in some cases but not in others; the second type of circulation may have failed to establish itself effectively.

Thus, researchers were faced with a very unusual problem. An organ which was essential to life produced no obvious secretions and had an unusual blood supply. Injection of X organ into other animals caused an initial increase in general metabolism but this stopped after a few days. It seemed to be an organ generally in control of body metabolism, producing some disastrous effects when not present.

It was then shown that increased quantities of amino acids increased the output of DNA and RNA from the X organ. Further analysis showed that the two nucleic acids were not separate but were short chains, locked together in the form of a triple helix. Various other compounds such as uric acid (the breakdown product of purine metabolism) produced similar types of triple helices, although not exactly the same molecule.

These molecules when injected into animals caused general increase in metabolism, the triple helix from amino acids causing an increase in protein synthesis etc.

This leads to the current hypothesis about X organ function. It appears to exert an overall metabolic control possibly by "switching on" genes in the cells of the body. Triple helices are produced in response to the products of cell breakdown and these stimulate further production of those substances which have been destroyed. This action does not seem to be general but affects some cells more than others. Much research remains to be done e.g. how is the triple helix broken up into cells? Is it by an active transport mechanism? How does it modify RNA synthesis and control cell function precisely?

Hastings Horseman Killed

The hoarding displays the news and the good people are flocking to read the details. The Hastings Horseman has bought it at last. Lived like a coyote and died with his boots on. Doors opening on the High Street at noon-time. Children and the old folk a-peepin' and a-smilin' to theyselves. Jesus hallelujah, they'll be sleepin' peaceful tonight right enough. Maybe the first time, Oh, I don't know, for years anyhow.

But is wasn't like that at all. He wasn't the fastest gun in the East, or one of your Apocalyptic riders. He wasn't a jockey or somebody we would know about. He was just an ordinary man who merited a hoarding and a headline and a headline for the first time in his life, when he died. In the devious or impoverished mind of some sub-editor the man's death appeared a commercial commodity. Citizen Kane sold newspapers.

The facts are these: an elderly man went out riding in a country lane on a Sunday morning. The wind hit a pile of rubbish and blew some old newspapers into the sky. The horse shied and the unfortunate man fell on to the tarmac and injured his head. He was taken to hospital where he became deeply unconscious and died within a matter of hours.

However unfortunate the incident may be, the circumstances cannot be considered particularly remarkable.

Perhaps we may examine the three words on the news hoarding and their juxtaposition and enquire whether they convey the truth, or whether there is evidence to suggest that they are intended to be conspiciously misleading.

The accident took place in the vicinity of Hastings and in that respect the use of "Hastings . . ." is in order. However, "Hastings Horseman" implies that this is a term of reference which will be instantly recognisable—"Oh him . . ." they all cried. Alternatively there are many Hastings horsemen whom we know about because doing things on horses has become a way of life for them. I suspect that the deceased rode a horse occasionally rather than continuously. Is he thereby a horseman ? I could fall off a horse and die quite easily precisely because I am not a horseman and have no business sitting on one. I suspect that non-horsemen are more often killed by horses than are horsemen but I stand open to correction. Nonetheless it is probable that the interests of alliterative impact would prevail and even I, falling off a horse on to my head, would become de facto and posthumously, a horseman. A centaur perhaps, in the great prairies in the sky.

Finally, he was killed. To die was not enough, since death may be as quiet as it is inevitable. There is no peace in killing, it is inherently violent and violence is a raw material for fantasy. That being so, the hoardings do not promise to tell the news because frankly the death of a man who falls from a horse on a Sunday morning stroll through a country lane is not news. The declaration on the hoarding elicits fantasies upon which it implicitly promises to elaborate. The fact that it fails to fulfil this promise is neither here nor there. By the time that the reader finds out he has paid his new pence and it is too late for anything but lingering regret that he has made a fool of himself once again.

There is an aphorism among newspapermen about "selling newspapers". It may be more difficult to get papers read and understood than sold. Possibly a publication with modest sales may turn out to be more carefully read since it attracts only an appropriate readership. And how is that measured in the year's accounts ?

M.S.R.

"Out, out, damned spot."

NURSING SECTION

A Question of Failure

Once again the results of the Final State Examinations have shown an alarmingly high rate of failure. Throughout the country, over recent years, these numbers have been arising, causing dismay and consternation to both the student nurses and their trained colleages.

It was not, however, always the case that there was a high failure rate. In fact in the larger teaching hospitals even as recently as a few years ago, it was an unheard of phenomenon for any nurse to fail. They might prove unsuccessful in the hospital examination but never in the National one.

Why then should this sudden change have taken place? Is the reason simply that the standard has been raised, or are there other causes?

To the first of these questions, the reply would seem to be that the style of examination has been altered, as well as possibly having a slightly higher standard introduced; the former proving the more important. Whereas, previously one could happily forget all knowledge of anatomy and physiology after the first year, this information has now to be retained through to the final examination. In addition the questions nowadays appear frequently to be extremely ambiguous as well as grammatically incorrect. This latter, unfortunately, was always a feature of the papers.

However, these considerations aside, it would seem that there are other reasons for this unhappy state of affairs.

In the first instance, there is the marked fall in the age of the average ward sister. These people are perfectly competent and frequently very good nurses. However, because they are much younger than was formerly the case, they are themselves still learning. Can they then rightly be expected to have the same ability to teach as did their predecessors? The answer would seem to be definitely not. Moreover, since the Ward Sister is frequently acting as "A Pair of Hands", she is unable to take another nurse with her, to whom she can demonstrate procedures.

Another factor which would appear to be relevant, is that nurses do not receive the amount of supervision which they should. During their third year of training, they are frequently left in charge of wards and are themselves undertaking the supervision. This, of course, is inadequate.

These are all factors which have emerged during recent years and would appear to be relevant. There are, however, other aspects.

The attitudes in Schools have changed radically over recent years. Education has become in many instances far less formal. As a result teenagers now experience less self-discipline than previously. It could be that they are unable to adjust when they arrive for training and that this is basically the cause of their failings? Secondly, are they

being given information which is of a far more complicated nature than that which is required for the examinations. It is interesting to note that nowadays nurses will discuss highly complex medical details at length but are incapable of performing a fairly simple nursing task. In addition, nurses training in small hospitals have frequently a much more sound basic knowledge than their sisters in the large institutions.

If these are some of the reasons, then action should be taken. The student nurses have become so perturbed by the thought of their examinations nowadays, that some have mentally failed before they even embark upon the ordeal. There is also a noticeable rise in the sickness rate at these times. It is surely wrong for this attitude to be allowed to continue. It is recognised that examinations will never be popular, and that there are people who react very badly in these situations. However, if it was once possible to retain a reasonable degree of equanimity, and maintain a high rate of success, is it not still a feasible proposition ?

GOODBYE LONDON BRIDGE

You that once spanned old Thames' historic stream
And daily bore your thousands to and fro,
To me are but fleeting thought or dream
That once had substance not so long ago.

Transported to Arizona plain
Above the Colorado still you stand,
A highway that feet will tread again
And leading nowhere in a lifeless land.

E. A. Penny.

CORRESPONDENCE

Who Discovered Insulin?

SIR,—I would like to reply to the comments on my article, "Who Discovered Insulin?" (*Gazette,* 19th June) by Drs. E. C. Noble and R. I. Macdonald (*Gazette*, 28th August).

Dr. Noble makes three criticisms :—

1. That he (Dr. Noble) has throughout the many articles written about the discovery of insulin, been slighted by the suggestion that he "did not appear" or "was ill" at the time when Banting was organising his experiments. Furthermore, Dr. Noble says that the story of he and Best tossing up for the first go in the experiments is true, and not apocryphal, as I suggested in my article.

Banting himself was indirectly responsible for some of the confusion. In his Cameron Lecture (*Edinburgh Medical Journal,* 1929, **36**, 1-18) Banting says: "Mr. Best won the toss. At the end of four weeks however, Mr. Noble did not return, and Mr. Best stayed with me." It is clear that the words "did not return" have been misinterpreted by all subsequent writers. Dr. Noble has told us that he did not return because Best was getting on so well with the experiments, and for no other reason. The confusion is not helped by Lloyd Stevenson, the author of Banting's biography (Heinemann, London, 1947, p. 79): "Drs. Best and Noble agree that the coin-tossing story is a fiction, invented by a newspaper reporter and repeated here (i.e. in the Cameron Lecture) without inquiry. Noble was not in the best of health at the time, and his home being close to Toronto he left at once for a holiday. Best's home was far away in the Maritimes, and he had previously decided to spend the summer working in Toronto." Dr. Noble has shown that this account is quite untrue, and I am sorry to have quoted it. The facts are that Noble and Best did toss up; Best won the toss and stayed on with Banting because he was getting on so well with the experiments.

2. Dr. Noble says : "That it was agreed that all the initial papers should appear under the joint names of Banting, Best, Collip, MacLeod and Noble". It is rather unfortunate that the papers containing the first detailed account of the experiments, and hence the papers most usually quoted (*J. Lab. Clin. Med.* 1922, 7, 251; 464) have only the names of Banting and Best attached to them. This is not in any sense intended to belittle the subsequent contributions that Dr. Noble made to the application of Banting and Best's discovery.

3. Dr. Noble calls me to task for not mentioning the work of Rennie and Fraser in the early days of insulin research. He is right : I could also have mentioned the names of Murlin and De Witt, each of whom prepared active pancreatic extracts before Banting and Best. But if these are added to the list in my article it is difficult to know when to stop; in retrospect the world's physiological laboratories in the first twenty years of the century seem to have been peppered with people hunting the insulin snark.

It is much more difficult to comment on the letter of Dr. Macdonald, since I disagree with a great deal of what he says. His first sentence states that my article contains inaccuracies, but never actually mentions what these inaccuracies are. He says that he does not want to "enter into an argument about who discovered insulin, for that fact is self-evident". However, a large part of my article was concerned with pointing out that the fact is far from self-evident; the word "discovered" would need to be defined carefully before the matter could even remotely be considered self-evident. Dr. Macdonald goes on to say that my references to MacLeod are "scurrilous". The only reference that I made that might be so interpreted was that it was remarkable that MacLeod should have been awarded a Nobel Prize for some research

done in his laboratory while he was on holiday. I still find this remarkable. If one were going to be scurrilous, one could suggest that insulin would never have been discovered in MacLeod's laboratory at all if MacLeod had been there; for he had a famous antipathy to Banting's project. But I did not say this; MacLeod's prize was given to him because he appreciated the significance of what Banting and Best had done, and encouraged the application of their discovery. I hope that I made this clear in the article.

I am, etc.,

J. R. HENDERSON.

Department of Physiology,
Guy's Hospital Medical School,
London, S.E.1.

The Rites of the Unmarried

SIR,—Your editorial on this subject will, I hope, make your readers more aware of how important it is for doctors not to take the easy and lazy way out whenever a clinical problem has moral overtones. To some patients blood transfusion presents moral problems, but few doctors would fail to try to get their patients to accept a blood transfusion if the clinical condition demanded it. To say "Oh, well, let the Church sort that one out" would not be generally regarded as a very responsible approach.

There are many clinical reasons why premarital intercourse is not in the best interests of patients. Infection of the Fallopian tubes may result in permanent sterility and the producing of an unwanted child may well upset the mother's mentality.

I believe, then, that we have a *clinical* responsibility to discourage premarital intercourse just as we have a clinical responsibility to discourage smoking. But we would be foolish to try to ignore any problem which has moral implications—for most have. The general picture of the Established Church today is that of an organisation out of touch with modern life and unable or unwilling to examine what Christianity has to offer today. There are some great exceptions to this generalisation. One of them is here in London. If any of your readers want to know what can be done to relate religion to the present day, I would recommend a visit to hear Bishop Goodwin Hudson on a Sunday evening at St. Paul's Church, Portman Square. The Church is in Robert Adam Street, off Baker Street. As an indication of how seriously he takes the problem, he has had a new church built, complete with fitted carpet, soft pews and luxurious lounge. A visit would clear up much confusion related to the problems which arise if we try to ignore all moral issues.

Yours truly,

T. H. S. BURNS.

'Newlands'
Edgehill Road,
London, W13 8HW.

Communication

SIR,—It is felt by many of the nursing staff that doctors of this hospital, when filling in communication sheets at the end of a bed, have little idea what to write in the column blithely headed "nursing care".

By the time he has finished clerking a patient, a house officer has little thought for the brief instructions to the nurses and usually resorts to such old favourites as "bed rest, up to toilet, and diet as able".

If it is thought an essential part of training for physiotherapists and radiographers to spend four weeks of their training on the wards gaining nursing experience, it would seem logical for medical students to do the same.

This would surely enable doctors, having donned their first white coat, to appreciate the problems facing the nurses. It would also help students to feel far more part of the ward team, rather than intruders simply there to take the occasional ml. of blood.

Yours sincerely,

CAROLYN REID.

The Nurses' Home,
Guy's Hospital.

Fund for Mr. Dudley

SIR,—I hope you do not mind my using your columns to remind the many friends of Mr. John Dudley, who was a short time ago obliged by ill-health to give up his work in this department, that the fund to which so many have contributed in order to make a suitable gesture of respect and affection, must be closed very shortly. Any of those who have for various reasons been delayed in making a contribution are asked to do so within the next few weeks.

Yours sincerely,

R. WARWICK.

Anatomy Department,
Guy's Hospital Medical School,
London Bridge, S.E.1.

BOOK REVIEWS

SELECTED WRITINGS OF SIR ARTHUR HURST (1879—1944).

Ed. by Thomas Hunt, C.B.E., D.M., F.R.C.P.
B.M.J. Publication Department, £2.00.

Few will deny that, as Bright was the Guy's physician of the 19th century, so Hurst has been (so far) the greatest of the 20th. Those who knew him retain a vivid memory of a slight, crooked, gnomish figure with piercing blue eyes and a personality like an H-bomb. He was dynamic, dominating, formidable, humorous, humane, kindly. One of the few Guy's Greats whom time has hardly diminished. His views, some of which are set forth in this book, and many of which were pretty revolutionary in their time, were sometimes wrong; he believed, for instance, that ulcerative colitis was "undoubtedly infective in origin". But most of them are now proved correct, and have become accepted medical belief. We owe, more than we often realise, a large part of our knowledge of the physiology and pathology of the gastro-intestinal tract to Arthur Hurst.

Deaf from an early age, he was debarred from practice in heart and lung disease. He flirted, not very successfully, with neurology and psychiatry and took an interest in asthmatics, being one himself. But it is as a gastro-enterologist that we remember and admire him. In this field he was supreme and without contemporary peer.

Hurst wrote prolifically, much of it for the Guy's Hospital Reports, in a lucid, objective style, with a quiet authority derived from his own enormous experience. In contrast to many of the turgid, indigestible, statistics-ridden "communications" of the present day, Hurst's papers are models of educated literacy; haute cuisine compared with meat-and-two-veg. (But perhaps this is more a reflection on the decline of medical scholarship in the last fifty years than a tribute to Hurst himself. Doctors wrote better in his day.) The best of his writing has been lovingly collected by Dr. Thomas Hunt for this book, which will be presented annually to the Arthur Hurst Memorial Lecturer by the British Society of Gastroenterology, which Hurst founded. There is an admirable Foreword by Professor Witts, an excellent biographical introduction by the Editor, some rather flattering portraits of the Author, and a slightly mysterious drawing of the Colonnade with Lowrie-like figures, done by A.F.H. himself when a student. And there is the distilled wit and wisdom of a brilliant intellect. An altogether delightful volume that everyone will thoroughly enjoy.

The book is available from B.M.A. House or Dr. T. C. Hunt, 53 Townshend Road, N.W.8.

J. R. F.

INTRODUCTION TO NURSING

This book is set out very well. The idea of dividing it out into sections with each one sub-divided makes it much easier for either the Junior or Senior nurse to study all aspects of nursing.

It includes not only nursing procedures but also a history of the Profession, and public communal health which will no doubt save the pocket of the new nurse as she will only need to buy one book, instead of three, which is of great advantage since her salary is very precious to her.

There is one part which I feel may confuse the Junior nurse and convulse the Senior nurse. That is the section about intravenous infusions. The book states that the taking down of infusions is carried out by the Medical Staff. This is something that I have never seen as routine.

Another point which I feel is an advantage is the idea of putting a list of books whereby the nurse can obtain further information. She need not buy these but is able to look them up in the library. Most schools of nursing have a very good selection of books in their library.

You will have gathered by reading this short review that I think the book is good value for money, and well worth £2.50 of any nurse's money (or kind relative's) be she pupil or student nurse.

SPORT

SQUASH RACKETS

USE OF COURTS

The location of the hospital's courts, off Borough High Street, and the fact that they are open around the clock, makes it almost impossible to keep an accurate check on who uses them. It has long been suspected that a few people who have no formal connection with the hospital manage to use the courts. Recently, however, this has become a far more common occurrence.

I would remind members of the hospital that this is not allowed. Furthermore, I would be grateful if members of the hospital would inform any "outsiders" found using the courts of this fact. In the next few weeks members of the Squash Club will challenge people they do not recognise. I hope that members of the hospital will not be offended by this rather necessary inconvenience.

BOOKING OF COURTS

As regular squash players will have noticed, the new squash court booking sheets came into use at the beginning of September. Apart from the new 45-minute periods, the booking system will remain unchanged, the new sheets being posted on Friday morning for the following week.

THE NEW SEASON

The fixture list has undergone fairly major revision this season. Last season's Cumberland Cup team was unable to hold its position in Division 4, and so will be competing in the 5th and bottom Division of the competition.

Since the start of the London University leagues four years ago, Guy's has always entered a team, usually on a fairly sociable basis. This season, we will be entering two teams. The first team will compete in Division 1 against some very strong opposition from other colleges, while the second team will continue as a social side, playing in Division 3.

The increase in the number of league fixtures has meant a reduction in the number of friendly matches against teams from outside the University. This is unfortunate, but it will mean that more players will be able to play competitive squash, which must strengthen the club in the years to come.

Although matches do not start until October, there will be practice sessions for probable first team players every Wednesday evening at 5.0 p.m.

The Squash ladder is now "open". The ladder and rules can be found on the club notice board, outside the students' bar.

E. J. EVANS.

A REVIEW OF THE 1971 CRICKET SEASON

The 1st XI has had an enjoyable and reasonably successful season with 30 matches played, of which 11 were won, 14 lost and 5 drawn. In all, 50 players have represented the side which explains the continually varying strength of the team and also the inconsistent performances. The individual performances were as follows:

BATTING

	Inns.	N.O.	Runs.	H.S.	50's.	Average
C. Langdon	26	2	601	83	4	25.0
R. Goodhart	22	5	482	80	4	28.3
G. Evans	18	1	421	81	3	24.8
A. Holland	15	2	303	76*	2	23.3
A. Gillham	16	1	284	62	1	18.9
R. Fitton	13	1	272	51	3	22.9
R. Clifford-Jones	13	0	243	50	1	18.7
J. Rees	18	1	119	29	—	7.0
R. Burns	10	1	86	18	—	9.6
M. Winter	9	2	77	18	—	9.6
J. Powell-Jackson	4	2	73	26	—	36.5

*denotes not out.

Winner of Batting Award: C. Langdon.

BOWLING

	Overs.	Mdns.	Runs.	Wickets	Average
R. Goodhart	249	70	721	52	13.8
S. O'Keefe	180	38	548	31	17.7
A. Davies	155	38	475	28	16.9
A. Gillham	121	25	388	26	14.8
J. Ramsay	177	43	601	19	31.6

Winner of Bowling Award: R. Goodhart.

CATCHES

21 — R. Goodhart. G. Evans (also 5 stumpings)
18 — C. Langdon.
12 — R. Clifford-Jones.
8 — J. Rees. A. Holland.
7 — R. Burns.
5 — M. Winter, D. Young.

Apart from the fielding, where R. Clifford-Jones especially must be mentioned for his outstanding fielding in the covers, and G. Evans who was generally in sparkling form behind the stumps, the performances were poor.

The batting was very mediocre when compared with last year when three players all scored around 700 runs. No one player was consistently scoring which explained some of the low scores. There were several really good innings but even the best batsmen must realise that application in every innings is vital.

The captain did an awful lot of bowling and realised 50 wickets but again there was really no one consistently taking wickets.

The highlights of the season were good wins over the Wanderers, Dragonflies, Bognor and Worthing, 9 wickets by Gillham in a match, the high scores and a catch by Reynolds!

The season ran very smoothly and was, I think, enjoyed by most, especially the tour which was very successful on and off the field. The one slightly worrying aspect of the Club is the ever-present rift between 1st and 2nd XI's. The 2nd XI have again had a happy season but many do not like playing for the 1st XI which is, understandably, much more serious cricket. It has been a particularly frustrating and thankless task fixing teams and by way of a reply to Ian Reekies' recent letter in the *Gazette* I would like to say that the hospital still boasts many fine players, two of whom have played for their county 2nd XI's. No one is proud of the fact that on occasion we have taken the field with 10 men—if all the good players would play regularly the side put out would be sufficiently strong to give any side in the country a run for its money. Apart from the usual cry of "apathy" there is definitely a swing away from sport in the hospital. Perhaps this is a result of U.C.C.A. which means that students are accepted to Guy's for academic ability and if there are sport-playing academics around this is an added bonus.

I can assure you, Mr. Reekie, we will do all we can to maintain the prestige among senior cricket clubs which you worked hard to promote.

Finally thanks to Robert Goodhart who captained Guy's for the second year running (and also United Hospitals this year) and to all the players who played for the 1st XI. In all we had five players represent U.H. and two played for the University. Also a special word of thanks to Stan Weller for the pitches and all his help and co-operation throughout the season.

HOSPITAL INFORMATION

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited for the post of **Research Registrar** in Renal Disease with duties to commence on 1st October, 1971, or as soon as possible thereafter. The appointment will be for one year in the first instance. The candidate, who should have the M.R.C.P., will be expected to join a group working on purine metabolism in renal failure. The project should provide suitable material for a thesis for the M.D. Application forms are obtainable from the Dean, Guy's Hospital Medical School, London S.E.1, and should be returned not later than **18th September, 1971.**

THE BOARD OF GOVERNORS OF GUY'S HOSPITAL, THE BOARD OF GOVERNORS OF ST. THOMAS'S HOSPITAL AND THE SOUTH EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited for the appointment of **Senior Registrar** in Thoracic Surgery to commence on 1st October, 1971, or as soon thereafter as possible, until 30th September, 1972. The successful candidate will work at Guy's Hospital. Application forms are obtainable from, and should be returned to, the Superintendent, Guy's Hospital, London, S.E.1, not later than **20th September, 1971.**

THE BOARD OF GOVERNORS OF GUY'S HOSPITAL

Applications are invited for the appointment of **Registrar** in the Department of Diagnostic Radiology at Guy's Hospital, to commence as soon as possible. Applications with the names of two referees, or enclosing two recent testimonials, should be sent to the Superintendent, Guy's Hospital, London, S.E.1, not later than **18h Sepember, 1971.**

GUY'S HOSPITAL HOUSE APPOINTMENTS

1st September, 1971
Additions to G.H.S. 71/71

Resident Obstetrician
Mr. S. A. Almohdzar

Senior House Officer to Nuffield House
Mr. M. G. Sutton

Gynaecological House Surgeon at St. Olave's
Mrs. A. Bhoomkar

P. J. Helliwell,
Superintendent.

PASS LIST

Doctor of Philosophy (Ph.D) Science
July, 1971

A. F. Winder (Biochemistry)

Doctor of Medicine (M.D.)
August, 1971

J. F. Hallpike — R. O. Weller

ROYAL COLLEGE OF SURGEONS OF ENGLAND

F.R.C.S.

June, 1971

J. I. L. Bayley — D. B. Mathias (Otolaryngology)
C. J. Davies
M. R. L. Joyce — R. J. Parker (Otolaryngology)
C. E. M. Lamb (Otolaryngology) — G. F. Rushforth
R. H. S. Lane — N. A. Watson
A. Martin

ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

M.R.C.O.G.

D. J. Browning — P. J. Rowe
B. W. Eliot — M. F. Rumpus
D. A. N. Johnson

ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH

F.R.C.P.

J. F. Cleobury — R. A. Miller
T. I. Francis — R. G. Spector

Academic Postgraduate Diploma in Clinical Medicine of the Tropics
June, 1971

F. F. T. Djabanor
With distinction

UNIVERSITY OF LONDON

First Examination for Medical Degrees
June/July, 1971

G. P. Feaver — Egil Olsen
Rosalie Lamensdorf — Vinaya Rajaratnam
E. M. Lee — J. R. Stenberg
Carol I. Mander — P. McE. Tillman

The following G.C.E. candidates have qualified for exemption from the first Medical:—

M. J. Browne — A. J. H. Markham
J. Burgess — Kathryn Marshall
A. M. Campbell — J. A. J. Serenyi
S. J. Christie — Hanna I. Skapski
G. Earnshaw — *Belinda J. Springett*
G. Evans — C. P. Stuart-Bennett
P. M. Fenton — M. P. Szasz
A. C. Fincham — N. M. Tarbet
N. D. Hatton — P. Treasure
Yvonne M. Hodges — R. E. W. Tyrer
R. H. E. S. Kirschen — Patricia M. White
A. R. Lethbridge — Margaret E. A. Wise
I. Litchfield

Second Examination for Medical Degrees
June/July, 1971

R. A. Botha — C. J. N. Lacey
R. W. Burns — P. W. Lambden
M. R. B. Cottrill — C. R. Mozley
R. D A. Coxon — P. R. Nicol
C. C. DeV. Crawshaw — H. D. T. O'Donnell
Rosemary J. L. Deacon — C. R. Pascall
Alison E. Dick — G. A. Richards
R. P. Fitton — Catherine M. Royce
J. E. M. Fox — W. A. C. Simpson
Patricia A. Godfrey — L. I. Sireling
T. J. Gray — Elizabeth J. E. Smith
Marta T. Karnicki — M. P. Stearns
Khoo Khui Teong — W. N. Trethowan
P. R. Kirtley — D. R. B. McK. Young

Third (B.D.S.) Examination in Dental Surgery
June 1971

Honours

K. P. J. Malone

Pass

B. M. W. Bailey — Susan Parry
C. H. Ballard — D. F. Pascoe
E. P. Brown — E. J. Shillitoe
J. S. Cowling — S. H. Ward
R. C. Croft — C. E. Wilde
P. R. Hunt — J. A. Williams
G. F. Langly-Smith

Part I

D. J. Allison
D. J. Beardsley
G. F. R. Bernays
M. J. Borsberry
M. J. Breen
M. S. Broadbent
M. Brummell
R. A. Burn-Murdoch
G. A. Chasak
J. A. Clark
R. H. Clark
P. A. Cooper
K. J. Cottingham
P. A. Day
T. J. Druett
N. M. A. El-Jabari
R. A. Elliott
R. K. Faulkner
R. C. Fell
M. L. Fennell
E. G. Fox
J. P. A. Harrison
Margaret M. Hirst
Betty A. Honeyman
M. J. Howes
D. F. Hoyos
Katherine V. Jones
A. W. Klyve
J. P. Lacey
Valerie S. Leathers
Jennifer A. P. Leithead
R. N. B. Lewis
S. Likimani
R. G. McQuillan
V. K. Maini
R. H. Miller
R. J. D. Milner
S. M. Milner
Y. Mohamed
D. A. Oram
R. G. D. Pinckney
M. Pollock
M. L. V. Portelly
C. J. L. Price
L. J. Read
K. F. Rigg
Anne Schlotel
K. A. Sheppard
Susan E. A. M. Smart
Monica R. Symes
J. M. S. Tan
Jennifer M. Turnpenny
J. Webb
C. P. Willis
Sandra Wills
J. B. Zukowski

Part II

M. F. Ashley
Theresa R. Bannerman
Ola M. Bjornaas
Elizabeth J. Bodycombe
R. E. Burt
G. W. Butcher
D. I. M. Carmichael
Christine A. Clark
H.-J. Crapper
Patricia M. Fernandez
M. J. Hughes
D. G. Jones
D. J. Merrett
R. K. Munday
Elizabeth S. Poulton
D. A. Stuart
S. D. W. Stuart
J. W. Tennant
S. Turner
S. M. P. Wright

Part III

J. Ah-Moye
D. T. Anderson
I. Bamford
Theresa R. Bannerman
D. E. Barker
Ola M. Bjornaas
R. M. Bye
J. A. Colman
D. R. Cottam
H.-J. Crapper
Penelope J. Davis
G. J. P. Dewe Mathews
M.McW. Drew
G. I. Eikrem
G. W. Emery
T. M Hudson
O. L. Jeeves
D. G. Jones
R. W. Kane
Hazel K. Kirk
R. C. Knowles
Sandra B. Lee
N. S. McLeod
G. B. Marcus
D. J. Merrett
Maire E. Morton
K. J. J. Moseley
R. K. Munday
G. R. Newman
S. B. Nilsen
J. C. A. Owen
A. Parker
N. A. M. Pearce
Diane Plamping
T. E. Reynolds
M. C. Roberts
R. G. Russell
M. A. Samji
T. P. Sands
M. L. Schaller
M. J. C. Shepherd
J. Standish
D. A. Stuart
D. R. Thompson
Lynne A. C. Turner
S. Turner
Katherine M. Walter
T. J. Walters
Elizabeth C. Williams
N. A. K. Williams
S. A. Winfield

PERSONAL

ASSISTANT/ASSOCIATE required in large single-handed dental practice central Brighton, owned by Guy's man qualified '56. Two fully equipped surgeries in use now Two spare rooms available for surgeries. BRI 61544.

CHANGES OF ADDRESS

From 16th September, 1971. Air Vice-Marshal and Mrs. R. C. Jackson, Pipers Hill, 19, Marwell, Farley Common, Westerham, Kent.

Dr. and Mrs. J. H. Newman, 12 Charlotte Street, Bristol 1.

Dr. W. Pryse-Phillips, 3777 Cote des Neiges, Montreal, Quebec, Canada.

C. P. Rodseth, B.Sc., M.C.S.P., c/o Baird Hall of Residence, University of Strathclyde, 460, Sauchiehall Street, Glasgow, C.2. from early October, 1971.

H. G. Ryder, L.D.S., R.C.S., Russell Kemp Home, Te Pene Avenue, Titahi Bay, Wellington, New Zealand. Tel: Wellington 7092.

Dr. J. F. Searle, University of Ghana Medical School, Department of Anaesthetics, P.O. Box 4236, Accra, Ghana. As from 24.9.71.

Dr. and Mrs. J. R. C. Sharp, 32 Palmerston Way, Alverstoke, Gosport, Hampshire. Tel: Gosport 87758.

MARRIAGE

NEWMAN—COX—On 31st July, 1971 at Cockington Church, Torquay, Dr. John Howard Newman to Elizabeth Anne Cox, S.R.N.

We would like to remind our readers that all copy for inclusion in the "Gazette" must be received eight days before publication date.

Copy may be sent to us c/o The Front Lodge, Guy's Hospital.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, please indicate whether or not this should be published.

Personal notices 5p per word (pre-paid) (minimum £1.05).

Non-subscribers will pay £1.05 (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

EDITOR A. M. TURNER
NEWS EDITORS C. G. CHINERY and D. I. F. KELLEHER
SPORTS CORRESPONDENT A. M. ROYSTON
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TEN PENCE VOLUME 85 NUMBER 2171

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

After Many a Summer

In recent weeks we have heard reports that a search is being conducted for drugs that delay the ageing process, perhaps even indefinitely. Now here is not the place to consider the worthlessness of such an exercise financially, or to do more than reflect that this is an up-dated version of the story that minced carp intestines eaten every day lead to everlasting respiration. The myth was based on the observation that carp lived in royal ponds for hundreds of years, so clearly their bowels held the secret to a perpetuity of stationary flotation at a level three feet below the surface of the world.

This is the place, however, to consider the reasoning behind an arrogant search for limitless longevity.

Common is the cry that if only we had time we could be tennis players, astronauts, poets and concert pianists. One of the essential sources of momentum for the spirit is the knowledge of what it would be capable if only it could either do several things at once or had a longer sentence in which to express itself.

Who would deny a guardsman outside Buckingham Palace a chance to do something more in life than stand absolutely stationary and be gawped at by people, inquisitive whether he is man or mindless robot, not even allowing himself to flick a fly off his face? There are, however, presumably many who enjoy the job and even enjoy fainting in hot parades. So perhaps they do not require our pompous sympathy; their job is so extraordinary they must enjoy it to do it at all. Would such a man benefit from an endless life standing stationary, or could he enjoy any other job?

A miner would thank you little for giving him drugs that keep him underground for a hundred years, for certain it is that we should not make social conditions or our distribution of wealth any different. He would be far happier to work until he could retire and enjoy his freedom then.

A richer person would, if he wanted suddenly to change from his boring office job to become a fighter pilot, have to suffer a great loss in status and income while training. It is unlikely he would tolerate that, so he would stay stuck in his office. Why prolong it?

Wisdom comes with experience, or so our grandparents tell us. Perhaps since so many of us have a great variety of experience before we retire and very little after, and we do not become classically wise until our old age, it is more the case that the insight of personal wisdom only comes with the ageing process.

It is probable that diseases such as rheumatoid arthritis proceed quietly and inexorably, disfigured hand in glove, with an advance in age. From a desire to cure such patients we should create a society that allows none other to follow it. We must know there is sufficient potential in the present selection of people to entertain themselves for ever.

The population problem could easily be solved by other pills. But we should be careful, for the society we would create would be of people in the physical condition of a twenty-five-year-old but in fact they would be about one hundred and fifty or possibly fifteen thousand years old, with no children, with no ability to be fertile and doing the same job as they have always done. They would be able to go and see the few children that would be born and reared to make up for the loss of life through accidents and odd acquired diseases.

In fact, contraceptive pills would not work. Most people would stop taking them in a desire for a messy child, and until all the women's ovaries had shed all their eggs, that would be dangerous. So there would have to be mass sterilisation of one sex or the other, probably both, to ensure complete success.

Above all they would have lost their succouring illusion that if only they had time they would be so many other wonderful people. Disillusioned, infertile, endlessly experienced, what a fine group of people they would be! Would they feel like carrying on, or would they press the famous button which will blow themselves and the world up?

GUY'S DIARY

SEPTEMBER

28 Tu Clinical Lecture. Mr. ELLIS.

30 Th Clinical Lecture. Mr. LAWRIE.

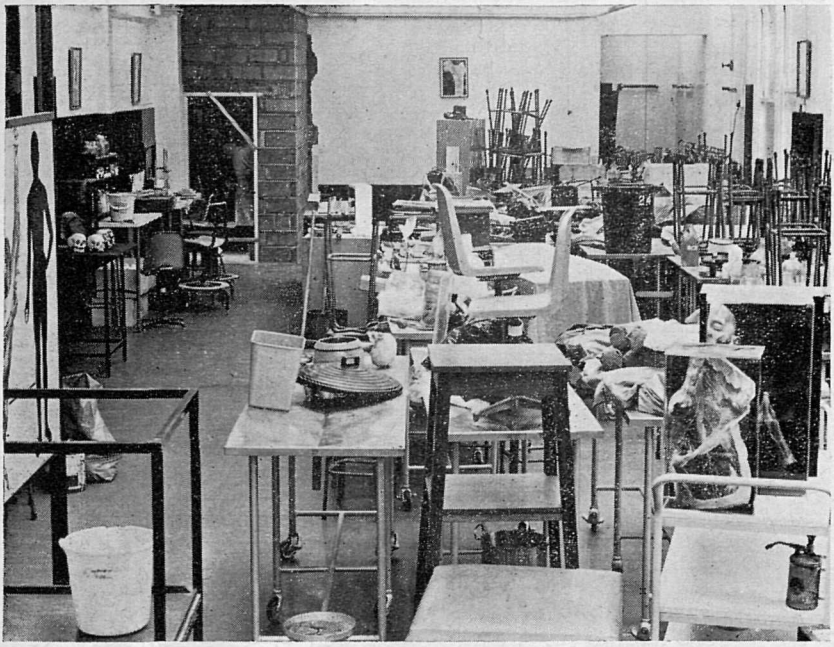
OCTOBER

5 Tu Clinical Lecture.
"Medical treatment through the ages—a hit or miss"
Professor LESSOF.

7 Th Clinical Lecture. Dr. STEVENS.

NEWS IN BRIEF

RECENT CHANGES IN THE ANATOMY DEPARTMENT



Morbid Chaos.

[Photo—T. Blackburn.]

The Dissecting Room

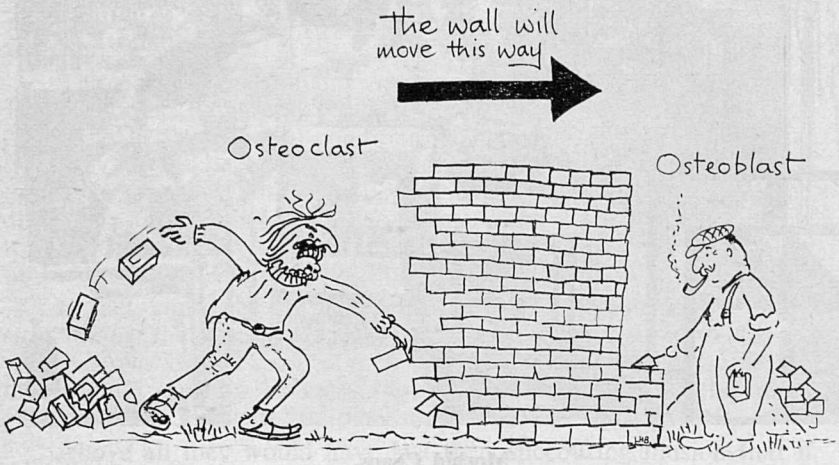
Recent inmates of the dissecting room are apt to take much for granted, but there are changes which would surprise the student of yesteryear.

Gone is the old hand-laid mosaic floor, which leaked into the Histology laboratory beneath, disturbing the desperate student in the middle of his examinations; in its place is plastic flooring, not only waterproof, but also very easy to keep clean. The old decor was given a face-lift only last year by introducing a two-tone motif of navy blue and white, garnished with reproductions of drawings by Vesalius on the walls. The original teak, and the more recent Formica topped tables upon which were kept the subjects of many hours' labour, have been superseded by self-draining, stainless steel tables, especially made for the job.

Even the characteristic odour was removed by a system of air freshening (an ingenious arrangement whereby a scented, deodorising spray was activated every 20 minutes)—in fact, everything had been done to make dissecting and working moderately pleasant. Unfortunately, however, the latter luxury has been axed due to economy.

Personal hygiene has also been taken into account by the installation of a stainless steel washing trough, liquid soap and paper towels, instead of workhouse type bars, soap and roller towels. No longer need lunch have a peculiar taste after a morning's work here.

At present the dissection room is in a state of ordered chaos, as seen, because a new preparation room is in the process of being made to facilitate the processing and production of specimens.



One of Dr. Bannister's histological "asides".

Teaching Techniques

The recently completed 2nd M.B. course is the first to be subjected to the full barrage of teaching aids at present available in the department.

Slide projectors and the occasional film are a help in lecturing. However, the use to which Dr. Bannister put the overhead projector and the TV camera in teaching histology must be an example to all lecturers.

The overhead projector is used for either pre-drawn, or quickly sketched diagrams, with artistic asides, whilst the closed circuit TV system is coupled up to a microscope, and allows the presentation of microscope slides on several TV screens for discussion by a large audience.

The use of TV has been pioneered by Professor Warwick for a number of years. Increased interest by a number of anatomy demonstrators, most recently Dr. Dussek, has culminated in a series of videotapes covering the dissection of the entire human body. These are shown on TV prior to dissection periods as a form of practical demonstration.

mps

medical
protection
society est 1892

Unlimited legal aid
and indemnity against
professional hazards
throughout the world
(except U.S.A.)

Secretary Dr. H. A. Constable. Head Office
50 Hallam Street, London, W1N 6DE. Tel: 01-580 9241
or Regional Secretary Dr. P. G. T. Ford
Regional Office: 30 Park Square, Leeds 1. Tel: 0532 42115-6

The results of a recent survey show that 76 per cent of students thought that TV was "of great value", the remainder thought it was of "some value". With this encouragement, future proposals include TV monitors in the dissecting room to provide on the spot aid to dissection, and greater use of "image magnification", where by zooming in with a camera, a magnification of x 50 of say, a specimen pot, can be achieved.

The emphasis of the teaching as well as the methods has undergone a radical revision. The weekly viva is replaced by a weekly tutorial, and vivas occur much less frequently, perhaps lamented by some. This is more in line with the change in approach adopted in the present integrated medical course.

The Dissecting Room Annexe

Of more interest perhaps to the clinical student, or even the postgraduate, resident or visitor, are the additions to the collection of "pots".

Corrosion casts have been done of the vasculature of various organs, including the heart, liver, lungs, brain and cerebral vessels. This is an ingenious technique involving the injection of liquid plastic into blood vessels brought to a high degree of effectiveness by Mr. Blackburn, technician to the department. The Anatomy Department now possesses as fine a selection of specimen dissections as it has ever had—many as a result of much painstaking work by Dr. M. C. E. Hutchinson. Some of these he has preserved and displayed in pots in the annexe. These include serial sections of the brain, both stained and unstained, to show the internal structure (by Dr. Rees), a unique dissection of the brain and spinal nerves, a dissection of the facial nerve, sections of the larynx and trachea, and an orientated dissection of the male genitalia and bladder.

He has also assembled a section of lung segments, including gelatin injected specimens to show the superficial representation of the segments in different colours, and corrosion casts to show the internal structure. This is of rather special interest to Guy's because of Lord Brock's original work on the subject.

In addition there is a fully assembled articulated skeleton of an achondroplastic dwarf. Could it be that in Dr. Hutchinson there is a John Hunter trying to escape—perhaps not in all respects of course?

The Navy is offering twenty-five medical cadetships this year. What are your chances?

Having passed your 2nd M.B., it all depends on you.

For our requirements are not simply your medical qualifications – but also the way in which your personal qualities match up to the demands of being a medical officer in the Royal Navy.

You see, as the only doctor on board, the entire medical responsibility for the ship's officers and men is yours. You might for example be somewhere in the Arctic or deep down in a nuclear submarine. In any emergency you are pretty well on your own. And that calls for some very special qualities.

But you're more than just a doctor.

Above all you are a naval officer – with the travel, the satisfaction and the full, rewarding life that every naval officer enjoys.

Of course all this happens after your registration.

In the first place, to qualify for a medical cadetship, you must pass your second M.B., or equivalent. After that you must be selected, following a Board interview.

Then while still at medical school, you are just like any other student. Except that we pay your fees and give you a guaranteed salary of £1,697 a year in the rank of Surgeon Sub-Lieutenant.

When you qualify you can spend your pre-registration year either at your hospital or one of ours.

After which we promote you to Surgeon Lieutenant, your pay goes up to £3,249 a year and you then begin your short-career commission with us for five years. When you leave us you'll take a lot of useful experience with you – together with a generous tax-free gratuity of at least £1,400.

In addition to 2nd M.B. students, the Navy also enters qualified doctors for a 5-year short-career commission. (Your application should be made during or after pre-registration year.)

Write now to Surgeon-Commander F. M. Kinsman, R.N., (26 AZ), Dept. of the Medical Director-General (Navy), Empress State Bldg., London, S.W.6, and tell him your age and qualifications. In return he'll tell you more about the advantages of applying for a medical cadetship or commission with the Royal Navy.

New Treatment for Bed Sores

R. Grahame

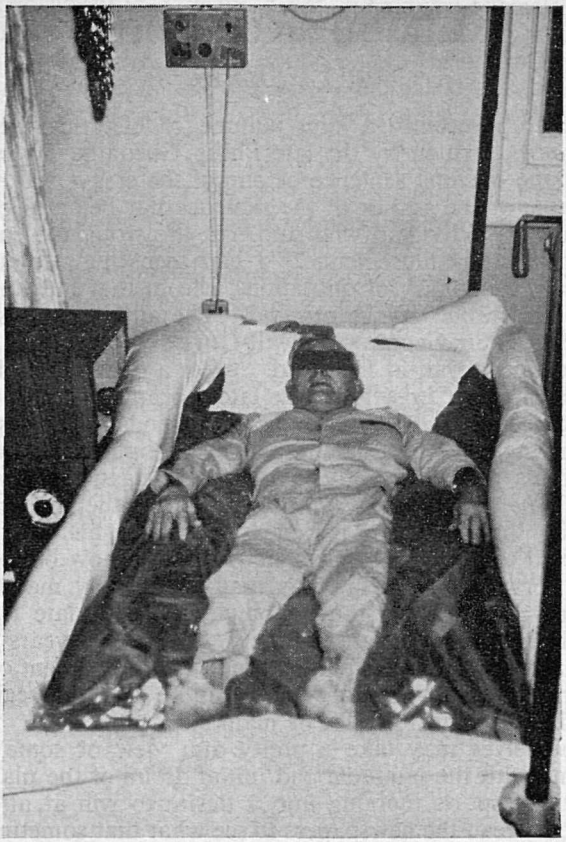
The treatment of bed sores has seldom aroused much interest among medical research workers. Yet this is surprising when one considers the enormity of the problem, both in terms of human distress and in the cost in terms of the resulting drain on precious nursing resources and of prolonged hospitalisation.

Bed sores, or decubitus ulcers, are caused by gangrene of the skin and subcutaneous tissues, resulting from prolonged obstruction to capillary blood flow by pressure on those parts of the body in contact with the bed. Thus, they are most commonly seen over the sacrum, buttocks or greater trochanters. The ulcers can occur very rapidly in patients suffering from paraplegia (in whom loss of sensation is added to total immobility) unless stringent precautions are taken for their prevention. They may, however, also occur in any elderly or debilitated patient confined to bed for a prolonged period.

Orthodox treatment relies on frequent repositioning of the patient, carefully avoiding any further pressure on or around the ulcerated area, and under these circumstances, healing may proceed gradually. At best, this treatment is both cumbersome and uncomfortable and may yet fail in its purpose. Skin grafting of these areas, too, is fraught with difficulties.

Over the past two years in the Hume Kendall Unit at Guy's-New Cross we have been testing a new method of treating severe decubitus ulcers using the Beaufort-Winchester Immersion Water Bed. The trial has been undertaken on behalf of the Department of Health and Social Security and our early results are most promising. The present bed, based on an original idea quoted by Sir James Paget in a lecture on the prevention and treatment of bed sores published in 1873, was invented by Dr. Russell Grant, of Winchester, in collaboration with Mr. Walter Neumark, chief designer of the Beaufort (Air-Sea) Equipment Ltd. It consists of a PVC-coated plastic water bath in which the patient actually "floats", separated from the water by a thin, movable layer of nylon sheeting. The temperature of the water is thermostatically controlled at 37°C and is continuously pumped from the water bed to the water heater and back by an electric pump. In the earlier model the water heater and pump was housed in a bedside cabinet, but in the 1971 model of the bed, which is raised on a plinth, the heater and pump are housed below the actual bed itself. With the patient lying supine on the bed the body weight is distributed equally over the whole surface of contact, so that at no point does the skin pressure exceed that obtaining the venous end of a capillary. It follows that the capillary circulation is not obstructed.

In practice, the patient lies in comfort and warmth whilst freedom of movement is retained. At the same time, healing of the bed sores progresses at an astonishingly rapid rate without the need of operative intervention. Several patients who have undergone conventional treatment for six months or more without success have now been



discharged home, their backs healed within six to eight weeks of starting treatment on the water bed. In more difficult cases, Mr. Ivor Broomhead has undertaken a rotation flap operation to cover large defects. During the post-operative phase the patient has been nursed on the water bed. The grafts have taken perfectly, despite the fact that the patients have actually lain (in comfort) *directly on the grafted areas.* This would clearly have been impossible on a conventional hospital bed.

It has taken a century for the idea of a water bed to become a practical reality. The Beaufort-Winchester water bed would appear to be an important advance in the treatment of bed sores. Our experience in the Hume Kendall Unit at Guy's-New Cross has shown that not only is it an effective form of treatment but that it is also well tolerated by the patient, many of whom have expressed how pleasant the sensation of "floating" is. Our hospital engineers have encountered no defects or problems of a technical nature. Furthermore, the demand on nursing facilities is greatly reduced and this at the present time is a very important consideration.

Random Reflections

G. L. Davies

Picking up recently a slim volume of historical essays called *The Liberators,* written by the late Philip Guedalla, I was surprised to see that the opening sentence of one of the essays was the following, the name of the author of the sentence not being given : "There was a mournful individual who said that life would be endurable, if it were not for its amusements." I had seen this quotation before in a standard dictionary of quotations, except that the word "endurable" was "tolerable" in the original. The author of this quotation was, it seems, a Sir George Cornwall-Lewis, whose statue still stands outside the Town Hall at Hereford. After a distinguished scholastic career at Eton and Christchurch he later became, in turn, Chancellor of the Exchequer and Foreign Secretary under Palmerston in the days when England was England as some people may now say. He figures for his political ability in that little classic, lately reprinted, Bagehot's *The English Constitution,* and in other historical works dealing with this particular period. He died in his early 50s, as so many seemed to do in those days, and, if I may now be so bold as to intrude a personal comment, it is that he was my maternal grandfather's first cousin. "History is bunk," said the late Henry Ford, whatever he may have meant by that. Nearly 200 years previously, Gibbon made a much more pertinent and adult comment on the same subject when he said: "History is little more than the register of the crimes, follies and misfortunes of mankind."

We ourselves may take a pretty dim view of some of today's amusements with the laudable and initial desire of the players to win in competitive sports merging into a desire to win at all costs, and one need only read the newspapers to see what that sometimes implies. Sir George Cornwall-Lewis, as a start to his intolerance, may have had a wholesome dislike of the philandering habits of his chief, Palmerston, for which he was notorious even in his own day. Other amusements of the time consisted then as now, no doubt, of fox-hunting, "the killing of the uneatable by the unspeakable," as Oscar Wilde called it later. There would be cock-fighting at the other extreme of society, bare-fist prize-fighting for the sporting fraternity of all classes, and of course drinking to excess in all classes, with its aftermath of gout and early death, no doubt largely from cardio-vascular disease. The "two-bottle" man who finished up under the table seems to have had some kind of status, whereas the man who "couldn't hold his liquor" was a very poor fish indeed. They order these things better in the England of today, one may perhaps say, but one reads that money spent on alcohol and tobacco runs into many millions of pounds each year, and that the sum has increased, is increasing and, naturally, one must add "ought to be diminished", if some of our worst killing diseases are to be eradicated.

We are now, medically speaking, in the era *par excellence* of psychosomatic medicine which is often called upon to treat men and women whose outward conduct often conflicts with the dictates of

their own conscience. "From envy, hatred and malice and all uncharitableness Good Lord, deliver us." The picture of my old headmaster intoning the words of the Litany from his little desk in the middle of the aisle of the school chapel still remains in my memory, and I realise only too well that it went in through one ear and out through the other. It takes a lifetime and two wars, and much besides, for the full significance of those words to soak properly into one's consciousness. How often, one wonders, do these unlovely human attributes form the basis of some of our psychosomatic problems: pretty often one imagines. *Homo sapiens,* as he likes to call himself, "that miserable two-forked radish," as Carlyle called him (plagiarising Falstaff of course) being what he is, with the record of the last fifty years behind him and with the synonym for "envy" being "oil" or "Lebensraum" or whatever happens to be convenient or urgent at the time, the words of any litany in any language whatsoever might be expected to receive scant consideration. And it is not as if wealth made for happiness or contentment. Our own domestic economy seethes with discontent and selfishness and apathy which are surely all a form of mass psychosomatic illness inspired very often largely by greed on the part of the more irresponsible members of the community, and that again by dull, monotonous, soul-destroying routine work which requires always more leisure time and more money to make it tolerable. All of this again will inevitably lead to national disaster unless some modern Canute is courageous enough to say: "Thus far and no further." "Crumple the lining of a jerkin," says Tristram Shandy, "and you crumple the lot." Which is as good a concept of psychomatic illness as anything. One has only to walk along a busy street to feel pretty certain that the inner life of people is expressed in the face: the calm, the beautiful, the dissipated, the depraved are there to be read, but not forgetting also the justifiable lines and wrinkles perhaps of years of pain and anxiety in some.

Harking back to my quotation from Gibbon earlier on, I am reminded—if such reminder were necessary—that this quotation was included in one of two letters written to me by Professor Payling Wright not very long before his sudden and tragic death. I never had the good fortune to know him either socially or academically; but, from the appreciation of him in the *Gazette* at the time of his retirement from Guy's, I saw that he had been at Exeter College, Oxford, in 1915. This coincided with one of the years when a very particular school friend of mine was also at the same college; and, if it is not being over-sentimental to feel saddened still at times over the memory of some of the friends of one's youth who were killed in the 1914-18 war, I decided to write to Professor Wright to see if he remembered my friend. However, as it happened, he didn't. As he said, he was only there for a few months before going into the Army and everything was in a state of flux at the time. My friend had by then evidently left, also for the Army, cheered on his way by a First in Classics, only to be killed in the early fighting on the Somme in a futile trench attack. Commenting on a photograph which I sent him for purposes of possible recognition, Professor Wright said:—

"Such portraits fill me with horror—the utterly senseless waste of some of the finest lives of our generation. Of six of my particular friends only one returned. . ."

". . . I am glad you enjoy Gibbon. In Rome it was corn and games; in England today it is cigarettes and soccer: Plus ça change, plus c'est la même chose."

As I have said, I never met Professor Payling Wright; but, judging by his two friendly and unhurried letters, and some further trouble that he went to for a complete stranger, I would say :—

"Take him for all in all, he was a Man."

NOTICES

Guy's Hospital Annual Dental Ball

To be held at the Grosvenor House Hotel, Park Lane, WC1, on Saturday, 6th November.

Tickets now available from Graham Brown and Subrette Smart. Price £6.80.

World Sausage Eating Championship

On Wednesday, 6th October, the Ancient Borough of Southwark will pit its intestinal fortitude against the best in the world. The aim is the golden acme of all gluttons. It is for the World Sausage Eating Championship. At the Woolpack public house in Bermondsey Street, not five minutes' walk from Guy's (but seven minutes) competitors will attempt to eat more than the record twenty-five two-ounce sausages in ten minutes. The competition is in aid of the Spastics Society, which provides the funds which finance the Paediatric Research Unit at Guy's. Competitors are to ask their friends for sponsorship for every sausage they eat in ten minutes. Sausages are provided free.

Entry forms obtainable from A. M. Turner, East Wing pigeon-hole.

Nobel Prize Multiple Choice Questions

Evidently the number of candidates nominated for Nobel Prizes has reached such a level that the foundation is no longer able to cope. In view of the success of M.C.Q. tests in elementary subjects such as medicine, economics, nuclear physics and reading, there is a move towards employing this method as a Part I for Nobel Prizes, Fellowships of the Royal Society and Academies of Sciences in New York, Moscow and Henley-on-Thames.

The following questions are submitted to specify the level of enquiry for anyone who may wish to try their luck:

1. To be or not to be;
   (a) That is the question.
   (b) That is not the question.
   (c) That is a silly question.
   (d) That is the wrong question.
   (e) That is the answer.
2. The point is;
   (a) In the doing.
   (b) In the book of Norman.
   (c) Sharp.
   (d) Lost.
   (e) At the top of the tent pole.
3. Goldilocks is sleeping in:
   (a) The big bear's bed.
   (b) Georgie Best's bed.
   (c) Edgar Sowton's bed.
   (d) This week.
   (e) Her own bed.
4. And is there shortbread still for tea?
   (a) Yes.
   (b) Shortbread's off.
   (c) Goodness me, is it ten to three?
   (d) This is an ironmongers.
5. Are the following statements true, and if so are they related:

The houses in front of London Bridge station are red *because* they hit more people than they miss *which is* a good thing for casualty officers who can learn a thing or two *but* often miss their tea *which* doesn't matter much *because* a pint of beer makes a nice change.

M.S.R.

OBITUARY

Dr. BRUCE CARDEW

He was a many-sided and complicated man, with a questing mind that made for inward tensions, and had the rarest of all gifts, originality and far-sightedness. He was born in 1904 at Orford, one of the most gracious villages in Suffolk, where almost all villages are gracious, and where his father was Rural Dean. His personality, even in the early days, did not equip him ideally for the restrictive and conformist life of British preparatory schools and the Royal Naval College, Osborne (a reunion dinner of which he recently attended with wry amusement). When Osborne contracted its numbers while metamorphosing into Dartmouth, Bruce Cardew transferred to Bromsgrove School which provided equally small stimulus for the flowering of his peculiar talents. He then went to Paris where his father, Prebendary F. A. Cardew, had become Chaplain of St. George's Church and founder of the Cardew Club (and Bruce served later on its London Committee), originally intended to protect the interests of British girls in the French theatrical world. As a traveller for Avery's, Bruce acquired a knowledge both wide and deep, and rare in Englishmen, of French colloquialisms, geography and culture. The last made a deep impact upon him, so that he always regarded France as far more civilised than Britain, and he took away a striking clarity and logicality of mind such as the French are traditionally supposed to possess. Sentiment seemed never to show itself in his thinking except in the department of family feeling and family tradition. He then widened his horizons further by working for the General Electric Company in the United States, of which land he also acquired a knowledge both wide and deep. He returned to Europe partly because of his mother's terminal illness, partly because of the economic depression, and partly because, as one of his brothers said, he "had woken up to the fact that he had a brain" and thought he could put it to better use. The voyage marked the beginning of a life-long friendship with the distinguished Guy's haematologist and astronomer, Dr. Reginald Waterfield. This started in the bar, with Reggie telling Bruce ("the most intelligent man I ever knew," Reggie once said to me), an anecdote about a Scots Minister. Bruce was quite put out at being told by a stranger what was a favourite story in his own family, but this led to the discovery that they had a mutual connection. It is a comment on those times and on these that the voyage ended with Bruce, finally persuaded that he would be prosecuted for importing obscene literature, throwing a first edition of James Joyce's "Ulysses" into the sea. It was now time for a decision on the future and, partly in response to the casual suggestion of a sister-in-law, he opted for medicine. His under-achievement and lack of stimulation at school made it necessary to go back and study for matriculation, which he cheerfully did, and then came to Guy's under the influence of Reggie Waterfield, whose charming cottage on Hedley Heath he came to share. This will be remembered by all surviving

contemporaries for the famous Guy Fawkes' parties with Reggie sighing "Isn't it all lugubrious?" and dispensing an innocent-looking fruit-cup which was doubtless responsible, as the night wore on, for the occasional discharge of horizontal rockets to the consternation of the scattering spectators. It was here that Bruce met his beautiful wife, still lovely today and still blending charm and toughness. They married in 1936 and had a daughter and a son. Her personal qualities were immensely supportive in times of trouble and difficult decisions. The married state was quite exceptional among students in those days but was fitting for Bruce who was far more travelled, experienced and sophisticated than his contemporaries. He expressed some of these qualities through editing the *Gazette*, and showed something of his flair for administration in a plan for increasing the number of take-in beds by a simple re-arrangement. The appearance of this in Passim led to an invitation (or summons) to dine at the Athenaeum with the Senior Physician, Dr. Hurst as he then was. Hurst had anticipated modern hippies through his habit of injecting himself through his trousers-pocket rather surreptitiously (though it was adrenalin for asthma), and he did this at the foot of the great staircase. To our surprise, for Hurst used only lifts, we were invited to climb it, but only to the first landing where (the only time I saw those sofas in use), Hurst picked Bruce's brains to such effect that he left for a committee after dinner armed not only with neat plans for re-organisation but with knowledge of many unpublished but projected ideas outside his own field, some of which (such as the re-naming of surgical wards), he seemed determined to oppose.

One supposes that at that committee he maintained his reputation for omniscience of hospital affairs. "Tch," said Bruce, "no cocktail and that dinner would have disgraced a fourth-rate Brighton boarding house." He qualified in 1939 taking, with his usual logic, the L.M.S.S.A., and, as he cared not for paper qualifications, leaving it at that. He went into general practice at Watchet, and was before his time in paying much attention to, but without over-emphasis, its psychiatric aspects. Distressed by the fall of France, he volunteered in 1940 for the R.A.F., and had quite a complicated war in North Africa and Italy before returning to general practice in 1945, but now in Bristol. Here, his aptitude for contentiousness came to the fore, a contentiousness which someone described as "always conducted with perfect civility," and indeed the perfection of his manners and his high sense of fun would never permit him to be tedious and, however, much out of sympathy one might feel, one had always to respect the logic of his unsentimental conclusions. He did not seek to be in a minority but was unruffled when he was. He was an avowed Socialist, became an active member of the Labour Party, and contested, though unsuccessfully, the election of 1945 at Weston-Super-Mare and of 1950 at Bath. Some years later, and again unsuccessfully, he sought election at Brentford and Chiswick. Meanwhile, a fluent, lucid and amusing speaker much involved in discussions in Bristol, his voice became influential in the West of England as he campaigned vigorously for the then medically unpopular National Health Service. In 1948 he

left medical practice and returned to London as secretary to the Socialist-orientated Medical Practitioners' Union which involved also editorship of *Medical World*. He used this position and his connection with the B.M.A. to further improvements in the development of the Health Service and general practice in particular, for the furnishing and equipment of which he ran an advisory centre. He lent vigorous support to the founding of the College of General Practitioners, which honoured him in the year of his death with its Foundation Council Award. In 1964 he decided to leave the Medical Practitioners' Union in favour of becoming medical adviser to a pharmaceutical concern interested in the furtherance of medicine and especially of general practice. Here he devised and organised the first film to show the working of general practice within the Health Service, advised on the economics of practice and, most important, successfully brought his now considerable influence to encourage the adoption of what he had long advocated (and which had so strongly been resisted), namely an appointments system in general practice. In 1966 he developed malignant disease of the chest. He faced this, of course, with his invariable realism, and in adversity his habits did not desert him. Apart from therapeutic intervals, he continued to work hard; his keen interest in life, and especially in people, was unabated; he travelled with enthusiasm; he listened to music, one of his great loves and about which he was highly knowledgeable, with his customary critical discernment; he was as skilled as ever at contract bridge which he had learned when it was invented during his time in U.S.A., and at which, with his logical mind, he was first-class by any standards, a Gold Cup player and the holder of silver cups and trophies. He was once heard by the family to complain, when he said that he would give half his kingdom for one day of feeling really well. After a final crisis he was determined to die at Aldeburgh with which he had long connections. On arrival he said to his daughter-in-law, "I've got four days' work which I simply must do, and then . . ." and spread his hands in a Gallic gesture. He did the four days' work and set various affairs in order. On the fifth day, 17th June, he stayed in bed and died. He was to the last handsome, urbane, stimulating, highly provocative and of the utmost integrity. The funeral was at Orford. The family walked in the garden, now embellished with Henry Moore and Hepworth, which they had known when young. The rubicund sexton had been a chorister of the Prebendary's and retained a testimonial from him. The organist had arranged the music with Bruce himself and played Bach from the Prebendary's scores. It was the Aldeburgh Festival and the family later went to the Mozart Requiem.

M.P

NURSING SECTION

The Changing Times

One of the most frequently heard laments which is listened to nowadays is that "things are not the same as they were". These words can be heard in every walk of life, but nowhere are they so vociferously proclaimed as in hospitals at the present time. Those who voice these dismal words of doom, are of course intimating that they wish for a total return to the days of yore. Is this a correct interpretation or is it merely a symptom of a very unstable society and a far deeper concern?

Unfortunately, in this day and age the trend is to dispense with anything which is traditional and introduce something new in its place, and nurses are suffering considerably in this respect. Moreover, what is proving most irksome is the fact that radical changes are planned, proposed, and introduced, with no reference whatsoever to the individuals who are most concerned and who will actually be directly involved. The age of diplomacy is, it seems, behind us, and dictatorial attitudes the order of the day.

Now no sane person would suggest that if progress is to be maintained then changes are not essential and also, it cannot be denied that the Nursing Profession requires more alteration and modernisation than a great many other organisations. In addition, nurses constitute one of the most hidebound and conservative groups of people in society. However, it would seem that changes and modernisation could be effected without the considerable trauma which is currently experienced.

Communications as all are aware, leave a great deal to be desired, but surely improvements could be made and thus, relationships improved.

It has been heard that the attitude of those who administer hospitals either in a lay or a professional capacity, is to make a decision and then present it without further discussion as a *fait accompli.* Unfortunately, apathy amongst nurses being as it is, these decisions are only questioned by a very few. They are promptly informed that no one else has complained, and that they therefore are merely being perverse. As a result, the amount of stereotyping and "red tape" increases to the general detriment and inconvenience of all except those who are not affected dirctly.

These methods are not calculated to prevent antagonism and they are the cause of a great deal of unrest. Whereas most would concede that changes are a necessary fact of life, they would, as intelligent beings, appreciate the opportunity to express their opinions, and, who knows, even make some acceptable suggestions. Most people are surprisingly reasonable if approached in the correct manner.

What seems to be apparent when one considers change, is not that nurses genuinely would wish to experience a regression to methods

and attitudes which are known to be obsolete, but that they would appreciate being included in the decisions. When one considers the ever-increasing size of hospitals, it is possible to envisage the difficulties involved. However, if certain large commercial organisations can prove themselves adept in such matters, it is surely not impossible?

Is not, then, this frequently heard complaint just resentment of the generalised depersonalisation and regret that one is not considered sufficiently worthy—despite the responsibilities of one's employment—even to be asked an opinion about a matter in which one is deeply concerned?

CORRESPONDENCE

Miss Linda Titley

SIR,—I am sure there are as many Guy's men and women who are as grateful as I am to Miss Linda Titley for returning to serve Guy's during this past three years, when she could have been enjoying a life of leisure following her retirement from St. Charles' Hospital, Ladbroke Grove.

As so many changes are taking place at this present time, it has been reassuring to know that the nursing aspect of the life and work of the hospital has been guided by Miss Titley in the light of her experience and knowledge of that which was worthy of the best traditions of Guy's.

May she now enjoy good health and happiness in what I am sure will be an active retirement, as she looks back in retrospect on her work of these past three years.

Yours faithfully,

JEAN RECKNELL.

Chantry Green House,
Steyning, Sussex.

Fill up your cups

SIR,—May I make use of your columns to advertise a unique opportunity for Guy's women to discuss informally, over a glass of sherry, the possibilities which are open to them in their medical careers, with those who have "made the grade" in a variety of fields, while enjoying a full family life.

The meeting will be held in the Medical School on Tuesday, 19th October, 1971, at 8 p.m., and is being arranged by Dr. J. Fullerton (Consultant Pathologist and Area Careers Advisory Officer for the Medical Women's Federation).

All clinical and recently qualified medics are invited. Drinks and sandwiches will be provided.

Yours sincerely,

LYNNE HAMPSON,
Student President.

St. Nicholas Hospital,
Plumstead, S.E.18.

The Rights of the Unmarried

SIR,—I should like to reply to the letter from T. H. S. Burns (*Gazette* 11th September).

He makes the point that "there are many clinical reasons why pre-marital intercourse is not in the best interests of the patients". He then cites but two, namely infection of the Fallopian tubes and the production of an unwanted child. I fail to see, why pre-marital intercourse, *per se*, should result in sterility any more than marital intercourse, unless concomitant with marriage is a hitherto undiscovered form of immunity from infection. Had he said promiscuity, with its consequent higher risk of venereal disease, then one might have to agree with him. Secondly the risk of a pregnancy can now be reduced to an absolute minimum by efficient contraceptive techniques.

The discouragement of pre-marital intercourse, on clinical grounds, is, then, of dubious validity. Advising one's patients not to indulge in pre-marital intercourse is likely to have even less effect than advising them not to smoke; it will probably only serve to antagonise them.

A doctor is a servant of his patient, he is not a judge of his morals. He may explain the risks of promiscuity, but he should not dictate to a patient on the conduct of his life. The result of a doctor striking moral attitudes, is that a patient may be frightened of consulting his doctor in connection with sexual matters. How frequently does one hear a patient say of his or her doctor "Oh! he is not the sort of man you can talk to about things like that!" This type of doctor-patient situation is all too common and it may cause patients not to seek the contraceptive advice they so urgently want, or not to go promptly for treatment of the venereal disease they have contracted, be they married or unmarried. Unmarried people, too, have their rights!

Finally, should some patients want moral advice all they have to do is to journey to Portman Square. There a Bishop, as proof of his modern outlook and serious intentions (according to Dr. Burns), has provided them with fitted carpets and a luxurious lounge. As they sink into their soft pews, will they wonder whether there are others in the world whose suffering might have been relieved by some of the money spent by a rich church in accordance with the most Christian ideal—the pursuit of luxury?

I am etc.

M. P. POWELL.

East Wing

The Rites of the Unmarried

SIR,—Once more, after a period of two years, the snail extrudes from his carapace, puts forth his eyes on the end of stalks and looks around, this time to see Religion placed in one of its correct relationships with medicine, expressed in a magnificent letter to you from Dr. T. H. S. Burns.

Hamlet says to Rosencrantz "There is nothing good or bad, but thinking makes it so". Fo-sho-hsing-tsan-Ching says "Regulate the mind and the body itself will go right". In the Dhammapada, a book of Buddhist morality, we find "All that we are is the result of what we have thought, it is founded on thought, it is made up of our thoughts".

Now, mind is a collection of symbols without a container, of which words are but one example, and thought is the use of words to explain those symbols. What is right and what is wrong is decided by the general opinion of the society to which we belong, and the rules are made and designed by the members of that society, to perpetuate the harmony and hence the existence, of that society. Man is made of mind and body, a psycho-physicality and it is the job of philosophy to see that they live together in harmony. Psychology is the study of the function of the mind, that is to say, thought. It is here that religion has one of its many parts to play in medicine. The psychiatrists, psychologists and ministers of religion all play their part. All the great religions insist that the ladder of spirituality will fail in its purpose until and unless the sandy base of the animal morality in man has been firmed, made stable and brought into order, for the bearing of the weight of the ladder of spirituality which is to be placed upon it.

It is for this reason that I am so pleased to see Dr. T. H. S. Burns refer those wayward members of his religion to their experts in the subject. Though I do not follow the same faith as Dr. Burns, it may be well to know that "As the different streams having their sources in different places all mingle their waters in the One Great Sea, O Lord. Similarly the different faiths which men follow through different tendencies or temperaments various though they may be, appearing crooked or straight, all lead to Thee".

Bravo! Dr. Burns, may there be many more like you who are not upset in their sense of values and who place their religion in the right space in the complicated jigsaw puzzle of medicine and refer their "patients" to the right people for sound advice. And thank you too, Mr. Editor, for your faultless judgment in the decision to publish Dr. Burns' letter.

With metta,

O. BALEAN.

Harcourt, 13 The Ridgeway,
Chatham, Kent.

Florence Taylor Memorial Fund

SIR,—At the last Annual General Meeting of the Guy's Hospital Nurses' League it was decided, in memory of Miss Florence Taylor, to purchase a new Sanctuary Lamp for the hospital Chapel, which played a great part in her life. If any of her colleagues and friends would like to be associated with this memorial gift, I would be pleased to receive donations.

Cheques or Postal Orders should be made payable to Guy's Hospital Nurses' League (Florence Taylor Fund) and addressed to me c/o. Matron's Office, Guy's Hospital, London, S.E.1.

Yours faithfully,

V. M. BLAIKLEY, (MRS.)
Hon. Treasurer,
Guy's Hospital Nurses' League.

Matron's Office,
Guy's Hospital,
London, S.E.1.

Whatever happened to the Wills' Library

(Baby Jane is alive and well and living in Montevideo).

SIR,—It is with distress that I feel driven to pick up pen to raise another matter of increasing concern to the students and staff of this Hospital. The Wills' Library, once an institution of which we could be justly proud, has shown a grievous degeneration in recent years, to the point at which it is barely useful for study, research, or pleasure. The discomfort of its chairs has probably given rise to more complaint in these columns than any other article of furniture. But do we have to tolerate tables whose tops bear only the most tenuous relationship to their legs, and which are wont to wobble alarmingly when one unwisely puts weight on them.

It is being stifled by an accumulating deadweight of old books, while the purchase of up-to-date works is limited, and capricious in the extreme. Many standard works published in the last three years have been neglected.

The noise is truly majestic—and a major contribution to this is made by the almost incessant chattering of the library assistants, and the mechanical maelstrom of the duplicating machine, the tramp of heavy feet, galumphing up and down the corridor, such that the Edinburgh Tattoo pales in comparison.

The coverage of modern journals is patchy and imperfect, and neither the wall-index nor the printed index covers all the journals or have been kept up-to-date.

Yours sincerely,

CONSTANCE SCHULTZBERGER, M.S.

Guy's Hospital,
London, S.E.1.

SPORT

FOOTBALL

1st XI v. OLD MALVERNIANS

On Saturday, 4th September. At H.O.P.

Guy's lost 6—5.

Guy's lined up for the first game of the season against a strong Old Malvernian side that included four of the team that won the Arthur Dun Cup. Guy's began confidently and dominated the early minutes, but after ten minutes the Malvernians scored a break-away goal with their first real attack of the game. Guy's reply was not long in coming, for Lindridge cleverly headed on Baker's long throw for Winter to equalise, and minutes later Winter put Baker through to score with a fine shot into the far corner. Baker at this stage was in tremendous form surprising everybody with his fitness, and he once again used his speed to get behind the back of the Malvern defence and score with a great shot from the narrowest of angles. With the defence playing well, Guy's continued to come forward and they went further ahead when Lindridge scored after being put clear by Winter.

Unfortunately, Guy's were never again to approach this form for the rest of the game, and the combination of a hard ground and a high sun began to take effect on already weary limbs. The Malvernians, lasting the pace better, continuously put high balls into the penalty area and three fine goals by their tall centre-forward put them back on terms soon after the interval. Attacks by the home team were few and far between by this time, but from one of these Winter scored to give Guy's the lead again. However, when the Malvernians equalised a few minutes later, hopes of a Guy's victory were past and a last-minute Malvern goal was scant justice to a Guy's team that had played hard and enthusiastically.

Team: R. Robinson; D. Allison, A. Godman, M. Brummell; J. Edwards, N. Harradine, P. Colley; B. Armstrong, D. Lindridge, C. Baker, M. Winter.

Reserves: K. Taylor, S. Drage.

MATCH v. ICARUS.

Saturday, 18th September. At H.O.P.

Draw 2—2.

Another blazing afternoon saw the rugged R.A.F. side confronted by Guy's without several of their regular players, who were mainly occupied at various weddings around the country. Mike Drew was back in the team for the first time since taking the plunge, providing a test case for the effect of all this nuptial activity on the standard of Guy's football.

An evenly contested opening fifteen minutes ended with Icarus scoring a soft goal due to lack of co-ordination in the defence. Guy's gradually took a very firm grip on the game and a good through ball saw Dave Lindridge catching the Icarus defence square and very neatly levelling the score. He made the second a few minutes later, planting a low cross from the left, right on to Jan Zukowski's foot.

In spite of exhortation for continued effort after half-time, Guy's started like a collection of tortoises and Icarus levelled the score when one Guy's back was left to mark two forwards. Guy's continued to be on the receiving end, but the seams just held, Rob Lewis going through a purple patch in goal. Football gradually re-emerged in the Guy's team and only the woodwork, early season rustiness and tiredness denied Guy's the victory they deserved in the closing part of the game.

MATCH v. HUGH SYMONS' XI

At H.O.P., Saturday, 11th September.
Won 4—3.

Seven goals and an equally elevated temperature were the characteristic features of this early-season game at H.O.P. Guy's fielded a side missing at least four first team players and began briskly, quickly gaining dominance in mid-field. The first score was an unstoppable curling shot from the opposition centre-half which dropped into his own net, giving Guy's a reward for their early pressure. Guy's continued to be that important bit sharper and goals by Colin Baker (1) and Mark Winter (2) followed rapidly. The four backs were feeling rather underemployed and the effort and cohesion were very gratifying at the beginning of a season with a depleted side.

The second half, however, was a story of gradual diminution of effort by the whole team. Guy's lost the initiative and good attacking moves grew rare. The three goals conceded, all reflected lack of concentration rather than superior football from the opposition and the root cause was undoubtedly simple lack of stamina. This was a very encouraging early win for the football club and bodes well for both first and second teams in the season to come. For the opposition mention must be made of a certain D. Lindridge, competently playing an unaccustomed defensive role to the frustration of his habitual colleagues.

RUGBY

GUY'S v. BROMLEY

H.O.P. 11th September. Result: Won 13—4.

Guy's started the season against a much fitter Bromley side with a convincing win.

Guy's started well and were pressing strongly when Bromley scored an unfortunate breakaway try. For the rest of the first half Guy's encamped on the Bromley "25" and were unlucky not to score more than Danford's penalty.

Guy's started the second half under pressure but fought back, and from a ruck following a line-out the ball sped along the line to Fitton on the left wing, who took his chance well. The remaining points were scored after the best move of the game when the forwards joined in the line after a loose ruck and Burt, easily recognised by his lack of shorts, forced his way to within a yard of the line before being brought down, and Rigg completed the formality by walking a yard for the try. Danford successfully converted.

Guy's looked promising in spells and with increased fitness have the basis for a better season than last year.

Team: 1 D. Stuart, 2 T. Gibson, 3 G. Marcus, 4 K. Rigg, 5 R. Burt, 6 B. Boyle, 7 J. Carter, 8 R. Massey, 9 C. Croft (Capt.), 10 A. Guest, 11 R. Fitton, 12 A. Campbell, 13 T. Druett, 14 R. Barough, 15 M. Danford.

HOSPITAL INFORMATION

GUY'S HOSPITAL BOARD OF GOVERNORS

The Board of Governors of Guy's Hospital invite applications from dental practitioners for the appointment of **Senior Registrar/Registrar** (full time) in Clinical Dental Surgery with duties commencing as soon as possible. Facilities for study and supervised research. The post will be subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff in the National Health Service. Forms of application are obtainable from and should be lodged with, the Superintendent, Guy's Hospital, London, SE1 9RT, not later than **12th October, 1971.**

THE NEUROSURGICAL UNIT OF GUY'S, MAUDSLEY AND KING'S COLLEGE HOSPITAL

Applications are invited for the resident post of **Senior House Officer** for six months commencing 1st November, 1971. The Unit which is housed in the Maudsley Hospital, serves Guy's, Bethlem Royal Hospital, the Maudsley Hospital and King's College Hospital. Applications giving details of experience and the names of two referees, should be made by 30th September, 1971 to House Governor and Secretary, The Maudsley Hospital, Denmark Hill, London, SE5 8AZ.

GUY'S HOSPITAL DENTAL SCHOOL

Commencing on Wednesday, 17th November, 1971 a course in Conservative Dentistry primarily for F.D.S. candidates will be held at Guy's Hospital Dental School. The course will consist of six sessions from 6.00 p.m. to 8.00 p.m. on 17th, 19th, 24th and 26th November, and 1st and 3rd December, 1971. Fee: £10.50. Further particulars and forms of application which should be returned as soon as possible and not later than 30th October, 1971, may be obtained from the Dean, Guy's Hospital Dental School, London Bridge, SE1 9RT.

GUY'S HOSPITAL

Senior Receptionist, Keats' House

A **Senior Receptionist** is required to fill the vacancy caused by the pending retirement of Mrs. Chuter. Salary scale in accordance with Higher Clerical Grade £1,170 to £1,461 plus London Weighting allowance of £90 per annum. The position calls for a lady with a pleasant personality, mature outlook and some managerial ability. Shorthand/typing, although an added advantage, is not essential. Enquiries about duties and application should be addressed to Mr. E. T. Loomes, Counting House Annexe. Telephone Extension 81/60.

PERSONAL

ASSISTANT/ASSOCIATE required in large single-handed dental practice, central Brighton, owned by Guy's man qualified '56. Two fully equipped surgeries in use now. Two spare rooms available for surgeries. **Tel: BRI 61544.**

CHANGES OF ADDRESS

Michael and Susan Faulkener to 14 Elmwood Close, Stokesley, Teeside, TS9 54X. Tel: 815.

Dr. and Mrs. T. H. Guerrier, 18 Knoll Crescent, The Drive, Northwood, Middlesex. Tel: Northwood 26852.

From 18th October, 1971: Margaret M. E. Trevelyan, S.R.N., S.C.M., c/o 2 Peabody Terrace, Apt. 1702, Cambridge 02138, Massachusetts, U.S.A.

Dr. and Mrs. J. A. Vale, 3 Merewood Close, Bickley, Kent. Tel: 01-467 1357.

BIRTH

ANDERSON—On 3rd September to Valerie (née Waters) and David Anderson, a daughter, Elizabeth Sarah.

SILK—On 4th September, 1971, to Rowena and David Silk, a daughter, Jennie Margaret.

MARRIAGE

VALE—JUBB—Dr. Allister Vale to Miss Elizabeth Jubb, S.R.N., S.C.M., on 4th September, 1971, at St. Helen's Church, Bishopsgate, E.C.3.

DEATH

THOMPSON—On 13th August, 1971 G. Tester Thompson, L.D.S., R.C.S. of Marney Lodge, 89 East Hill, Wandsworth, London, S.W.18.

PAPERS BY GUY'S MEN

Appleyard, W. J., Hyperuricaemia and renal failure preceding onset of acute lymphoblastic leukaemia. *Proceedings of the Royal Society of Medicine*, 1971, **64**, 728.

Collins, J. V., Harris, P. W. R., Townsend, J., Clark, T. J. H., and Goulding, R. Plasma-11-hydroxy corticosteroid levels in drug-induced coma. *Lancet*, 1971, **2**, 184.

Cooper, D. K. C. Accidents in agriculture. Injury. *The British Journal of Accident Surgery*, 1971, **3**, 1.

Cooper, D. K. C. Transplantation of the heart. *Nursing Journal of India*, 1971, **62**, 69.

Emslie, R. D. Fluoridated milk. *British Dental Journal*, 1971, **131**, 51.

Evans, P. R. Unusual forms of epilepsy. *Pakistan Paediatric Journal*, 1971, **1**, 31.

Falconer, M. A. Genetic and related aetiological factors in temporal lobe epilepsy. *Epilepsia*, 1971, **12**, 13.

Fry, J. Hospital referrals: must they go up? *Lancet*, 1971, **2**, 148.

Hayward, J. L. and others. Relation between urinary androgen and corticoid excretion and subsequent breast cancer. *Lancet*, 1971, **2**, 395.

MacFarlane, D. W. An improved intracoronal splint, *British Dental Journal*, 1970, **128**, 492.

MacFarlane, D. W. The dynamic stiffness of toothbrushes, *Journal of Periodontal Research*, 1971, **6**, 218.

McKusick, Victor A. and Wells, R. S. Genetics in relation to the skin. *Dermatology and General Medicine*, McGraw-Hill, New York, 1971.

Peachey, R. D. G. and Wells, R. S. Hereditary hypotrichosis (Marie Unna type). *Transactions of the St. John's Hospital Dermatological Society*, 1971, **57**, 157.

Rees, R. J. W. and another. Fate of *Mycobacterium leprae* in macrophages of patients with lepromatous or tuberculoid leprosy. *International Journal of Leprosy*, 1970, **38**, 439.

Rees, R. J. W. and others. Lymphocyte-mediated modification of blood-derived macrophage function *in vitro*; inhibition of growth of intracellular mycobacteria with lymphokines. *Clinical and Experimental Immunology*, 1971, **8**, 625.

Rosin, A. J. Alcohol excess in the elderly. *Quarterly Journal of Studies on Alcohol*, 1971, **32**, 53.

Ross, D. N. and others. Coronary artery surgery. *Proceedings of the Royal Society of Medicine*, 1971, **64**, 766.

Ryan, T. J. and Wells, R. S. Hereditary benign telangiectasia. *Transactions of the St. John's Hospital Dermatological Society*, 1971, **57**, 148.

Sowton, E. and others. Effect of practolol on exercise tolerance in patients with angina pectoris. *American Journal of Medicine*, 1971, **51**, 63.

Turk, J. L. and others. *In vivo* action of soluble mediators associated with cell-mediated immunity. *International Archives of Allergy and Applied Immunology*, 1971, **41**, 18.

Walter, J. D. An assessment of alginate. *Dental Practitioner*, 1971, **21**, 377.

Wilson, Derek, Psittacosis. *Journal of the Royal College of General Practitioners*, 1971, **21**, 506.

BOOKS

Brookes, M. The blood supply of bone: an approach to bone biology. Butterworths, London, 1971.

Killey, H. C., Kay, L. W. and another. An outline of oral surgery. Part 1. John Wright, Bristol, 1971.

Maclean, K. and Scott, G. Medical treatment. Vol. 4. Churchill, London, 1971.

We would like to remind our readers that all copy for inclusion in the "Gazette" must be received eight days before publication date.

Copy may be sent to us c/o The Front Lodge, Guy's Hospital.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, please indicate whether or not this should be published.

Personal notices 5p per word (pre-paid) (minimum £1.05).

Non-subscribers will pay £1.05 (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

EDITOR A. M. TURNER
NEWS EDITORS C. G. CHINERY and D. I. F. KELLEHER
SPORTS CORRESPONDENT A. M. ROYSTON
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TEN PENCE VOLUME 85 NUMBER 2172

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

How to Judge

Medical examinations are curiously complex affairs and the mixture of assessment by personal view and ever so objective multiple choice examinations at Guy's is particularly curious. Later on, in about four paragraphs' time, I am going to conclude that we ought to treat academic examinations in a consistent way and provide an academic period for study or revision before them. But first it would be worthwhile to consider the nature of the tests of medical students' abilities.

The system of apprenticeship for three months to a senior or group of seniors, who teach and continually assess students on their ability, is a splendid way of keeping both sides in touch with each other. But most firms now, despite the close link between teachers and taught, rely to a varying extent, sometimes exclusively, on a multiple choice examination to assess their students. The arguments in favour of such a system are that the assessment does not depend upon the relationship between preceptor and pupil. Such objectivity releases the student and allows him to buy apples or bumper firm dinners for only those consultants he likes, without fear of being suspected of toadying. It is also a great deal easier in practice to rely on a clear examination result than for the assessor to make certain that he knows all about how each individual is getting on with his studies.

It would appear that neither of these reasons is consistent with what is considered the recommended situation. Scurrilous it would surely be to suggest that assessment without an examination was made on a personal prejudice of the physician or surgeon that was not related to the students' ability in clinical matters. The reasoning that the teachers are not interested enough in teaching to be well acquainted with their students' progress can also not be followed in a system of such a good ratio of students to teaching staff, and

moreover in a system which has such frequent contact between the two when compared with other university degree courses. So why do we have assessments on multiple choice questionnaire achievement? The answer to such a question is perhaps "Why not?" That is readily answered. An examination assessment ignores the routine clinical work that a ward clerk does on the wards with his patients. Is it little wonder that there are so many complaints of students taking too little personal interest in their patients if they already know about the diseases their patient suffers from? It also encourages people further to consider that success in medicine is measured in the skill with which a multiple choice questionnaire is dodged through. Now it is questionable whether doctors can be graded for clinical ability in an excellent multiple choice questionnaire. When the questionnaire falls well short of excellent the relationship between performance in it and what that performance is intended to represent is much less well understood. Paper exams miss so much of what goes on in the wards. It would be a clever one that tested the ability to distinguish a suspicion of pale skin from anaemia, ruddyness from cyanosis or obesity from Cushing's disease.

There is at the moment a place for examination of both essays and multiple choice questions in medicine. During the course they can be used as a teaching device. At the end of medical training it is necessary to have an independent assessment to ensure an individual is safe to practise, that there are no gaps in his knowledge which will allow the cursed infidel, ignorance, to overwhelm his judgment. For these examinations it is fair and necessary to give a student leave to prepare. Through good teaching on the wards he is prepared for the practical exam and has much of the material for written examination, but essay questions require a special approach and that involves a special time devoted to the subject to ensure success. By shortening each of the firms' appointments by three weeks there would be six weeks to revise for each of the two parts of finals.

Let us recognise that the present situation of students taking time off Front Surgery and various ward duties to revise, is an unnecessary clash within the hospital. There is a place for written examinations and also for clinical training and assessment. They should complement, not clash or be confused.

Free Contraceptives for Women

As it has been ever since Adam took the apple from Eve, the eternal debate about sex, morals and marriage goes on. These topics have probably had as many words said on them as any other since man has been around.

The current generation is said to have a more permissive, or perhaps just a more honest attitude to it. For sure, whatever the currently popular views, or anyone's personal view, nobody can possibly expect that they can ever stop promiscuity. However, this generation certainly has one factor to differentiate it from those in previous eras, and this is the advent of inexpensive and reliable contraceptive methods.

Conception has always been the ultimate weapon in the armoury of the moralists. The child resulting from a casual sexual union is placed in a very difficult position, unplanned and unwanted, with no place in society. Today this need not happen, and so, it is said, promiscuity is only the responsibility of the consciences of the two people involved.

Be that as it may, a large number of children are still born under the wrong circumstances; these are the people who suffer the most. The London Borough of Islington has 900 children in its care. Most of these children need not have been born into these circumstances, had the advances in modern science been used.

Every person is free to obtain contraceptives somewhere, somehow, for some sort of charge. Fine, the child care facilities in Islington cost £900,000 per annum. Against this, free contraceptives for women over 16 years of age will cost an estimated £10,000—£15,000 a year.

Provision of such a free service will not relieve Islington of providing a child care service, nor relieve the N.H.S. of terminating pregnancies, but it is very difficult to believe that this service will not result in some long-term reduction in the number of children in care and terminations.

If the service is well run, and well used, visible financial profit should make it a good investment, whilst the invisible earnings in the form of lack of human suffering to potential mothers, unwanted children, and their mothers, will be much more difficult to calculate, but probably also much more substantial. Such a scheme deserves support; prevention is always better than palliative treatment. Perhaps this is what medicine is all about.

NEWS IN BRIEF

University Degrees

At the request of the University of Oxford, the University of London has recently amended the Regulations for the M.B., B.S. Degrees for Internal Students to allow Oxford medical students who do the clinical course in London the option of taking the London M.B., B.S. Degrees instead of the Oxford B.M., B.Ch. A similar option has been given to Cambridge medical students doing the London clinical course. A student who wishes to exercise the option may apply to the University of London to register as an Internal Student and provided he furnishes satisfactory evidence of his standing as a clinical medical student he will be exempted from the Second M.B., B.S. Examination and permitted to proceed directly to the course of study leading to the Final M.B., B.S. Examination. The option should therefore be exercised before commencing the clinical course, and so its existence is unlikely to be of concern to students who are already at Guy's.

New Integrated Course in Pathology and Bacteriology

The new course has been arranged, and the time-table is available from Mr. Wallace, Medical School Office.

It can only be hoped that the time-table has been or can be integrated with other clinical activities.

Closed Circuit Television

The School is in the process of being connected to the Inner London Education Authority's closed circuit television network; and in a day or two we hope to be able to receive the programmes.

Channel 7 of the network will carry higher education programmes, and those which will be of medical educational interest will be shown in the Anatomy Lecture Theatre as detailed below.

Classrooms 1 and 1A are being wired up so that small groups will be able to watch future programmes in one or other of these rooms, and by modulating the signal it will also be possible for programmes to be shown to larger audiences in the Anatomy Lecture Theatre or the Biology Classroom. The number and range of programmes of interest to members of the School are likely to increase and it is intended to make those programmes available within the School which are considered to be of value to members of the School.

The following Television Programmes will be shown in the Anatomy Lecture Theatre:—

Mondays at 5.30 p.m. (11th October—6th December).—The Scientific Basis of Medicine.

A series of Lectures especially for Junior Staff and research workers:—

11th October.—Professor A. F. Huxley, F.R.S.: Muscle Contraction: The Contraction Process.

18th October.—Professor A. F. Huxley, F.R.S.: Muscle Contraction: Activation of the Contractile Material.

See "Guy's Diary" for future lectures.

Tuesdays, at 5.0 p.m. (12th October—December).—Clinical Medicine.

A series of lecture-demonstrations of clinical and emergency procedures, including emergency procedures for diabetic coma, cardiac arrest and status epilepticus and clinical techniques such as taking an ECG and simple lung function tests; primarily of interest to Junior Hospital Doctors.

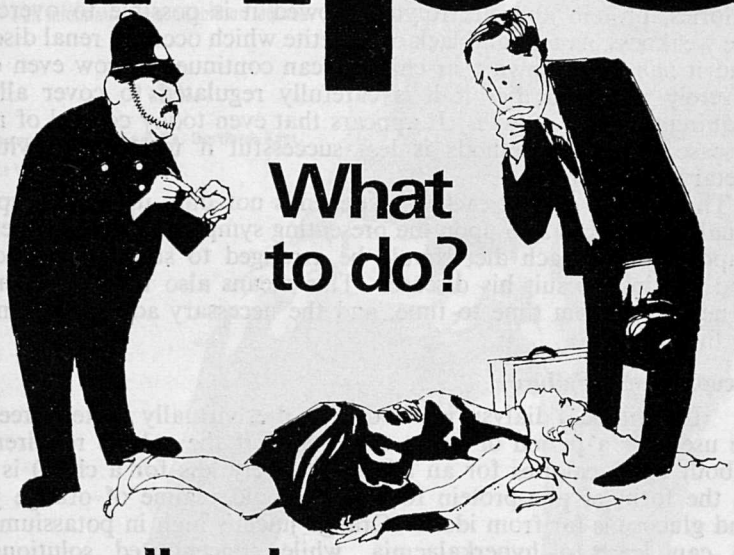
Tuesdays at 6.0 p.m. (12th October—December).—"Update".

A series of programmes for continuing medical education, covering recent advances in medical research and their applications to medical practice; topics will include a series on contraception and cardiology.

Better Security at Guy's

Guy's beat MI.5 to it. A few days before the big spy purge, Guy's Hospital installed a sentry box at the ancient main gates. However, it is feared that "changing the porter at Guy's" will not become one of the star tourist attractions of London, even of South London. Indeed, the purpose it seems is to allow an even greater control of the use of the car park, alternative parking is arranged c/o Metropolitan Police, at the Elephant and Castle Car Pound.

mps



medical protection society est 1892

Unlimited legal aid *and indemnity against* professional hazards throughout the world *(except U.S.A.)*

Secretary Dr. H. A. Constable. Head Office
50 Hallam Street, London, W1N 6DE. Tel: 01-580 9241
or Regional Secretary Dr. P. G. T. Ford
Regional Office: 30 Park Square, Leeds 1. Tel: 0532 42115-6

The Dietary Treatment of Renal Disease

P. M. Newland

The restriction of dietary protein in the treatment of renal disease has been practised for generations, but the newer technique of peritoneal dialysis and haemodialysis together with modern chemotherapy, have not rendered dietary control obsolete. Indeed, the right type of diet can play a very important part in improving the well-being of a patient. By the manipulation of the amounts of fluid, calories, protein and electrolytes allowed it is possible to overcome the weakness, nausea and lack of appetite which occur in renal disease, and it has been shown that children can continue to grow even on a severely restricted diet if it is carefully regulated to cover all the requirements for growth. It appears that even today control of renal disease by other methods is less successful if undertaken without dietary regulation.

The type of diet in each case depends not only upon the type of renal disease, but also upon the presenting symptoms. It is, therefore, important that each diet should be arranged to suit the individual, and not just to suit his disease. This means also that reassessment is necessary from time to time, and the necessary adjustments made in the diet.

Acute Renal Failure

If peritoneal dialysis is not used, a diet virtually protein-free can be used for a period of up to two weeks, if the calorie requirement (about 2,000 calories for an adult, relatively less for a child) is met in the form of non-protein foods. The old régime of orange juice and glucose is far from ideal. Orange juice is high in potassium and so can lead to hyperkalaemia, while concentrated solutions of glucose may cause nausea and diarrhoea owing to the high osmotic pressure of a concentrated glucose solution. Hy-Cal and similar products are now available which provide high calorie solutions of low osmotic pressure and of a suitably low electrolyte content. Unless there is excess water loss due to a rise in temperature, the total fluid given in 24 hours should be about 500 ml above the volume of the previous day's urinary output.

If, after two weeks, the renal failure persists, protein must be introduced. For an adult, 20 g protein per day is sufficient if this is derived from protein foods of high biological value. Two eggs and 200 ml milk will fulfil this requirement and provide about 300 calories. The additional 1,700 calories needed can be made up from non-protein sources as before. Fluids and protein can be kept at these levels until diuresis occurs, when both can be progressively increased as improvement continues. It is important, however, not to introduce at too early a stage orange juice, tomato juice, or instant coffee which contain a high concentration of potassium.

Transform the Parkinsonian patient with

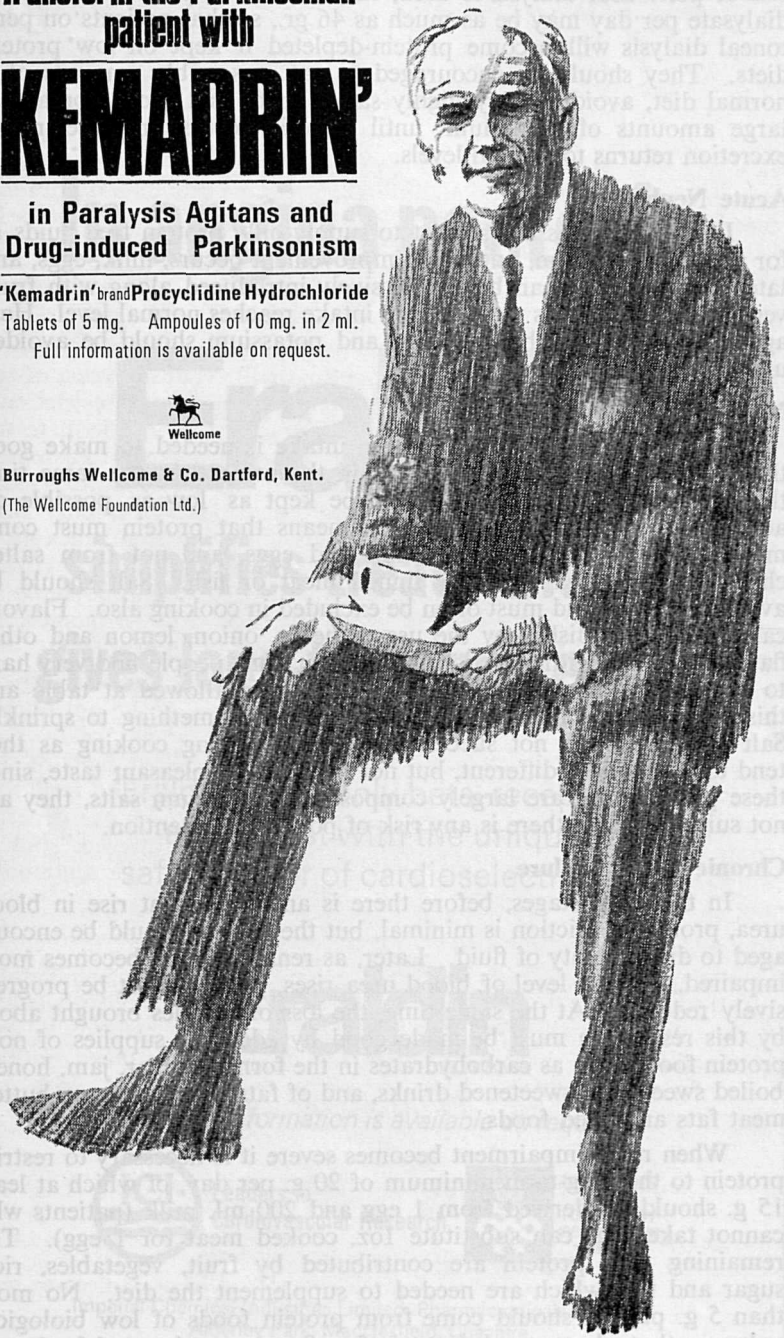
'KEMADRIN'

in Paralysis Agitans and Drug-induced Parkinsonism

'Kemadrin' brand **Procyclidine Hydrochloride**
Tablets of 5 mg. Ampoules of 10 mg. in 2 ml.
Full information is available on request.

Wellcome

Burroughs Wellcome & Co. Dartford, Kent.
(The Wellcome Foundation Ltd.)



If peritoneal dialysis is used, the amount of protein lost in the dialysate per day may be as much as 46 gr., so that patients on peritoneal dialysis will become protein-depleted if kept on low protein diets. They should be encouraged to eat reasonable amounts of a normal diet, avoiding very highly salted foods and foods containing large amounts of potassium until diuresis occurs and electrolyte excretion returns to normal levels.

Acute Nephritis

It may be necessary at first to supply only protein free fluids as for acute renal failure, but when improvement occurs, milk, eggs, and later meat and fish can be progressively introduced along with fruit, vegetables and cereals until protein intake reaches normal level. Here again, foods very high in sodium and potassium should be avoided until normal renal function returns.

Nephrotic Syndrome

In this condition a high protein intake is needed to make good the severe loss of nitrogen excreted in the urine. At the same time the salt content of the diet should be kept as low as possible on account of sodium retention. This means that protein must come mainly from fresh meat, fish, milk and eggs, and not from salted cheese, other salted foods or tinned meat or fish. Salt should be avoided at table and must often be excluded in cooking also. Flavour can be put into dishes by the use of herbs, onion, lemon and other flavourings, but salt restriction is a burden some people find very hard to bear. It often helps if a salt substitute is allowed at table and this gives the psychological benefit of having something to sprinkle. Salt substitutes are not successful if added during cooking as they tend to give food a different, but not particularly pleasant taste, since these preparations are largely composed of potassium salts, they are not suitable where there is any risk of potassium retention.

Chronic Renal Failure

In the early stages, before there is any significant rise in blood urea, protein restriction is minimal, but the patient should be encouraged to drink plenty of fluid. Later, as renal function becomes more impaired, and the level of blood urea rises, protein must be progressively reduced. At the same time, the loss of calories brought about by this restriction must be made good by adequate supplies of non-protein foods such as carbohydrates in the form of sugar, jam, honey, boiled sweets and sweetened drinks, and of fats such as cream, butter, meat fats and fried foods.

When renal impairment becomes severe it is necessary to restrict protein to the long-term minimum of 20 g. per day, of which at least 15 g. should be derived from 1 egg and 200 ml. milk (patients who cannot take eggs can substitute 1oz. cooked meat for 1 egg). The remaining 5 g. protein are contributed by fruit, vegetables, rice, sugar and fats which are needed to supplement the diet. No more than 5 g. protein should come from protein foods of low biological value, so that wheat starch (protein-free flour) must be used for bread,

In angina pectoris

Eraldin

simplifies treatment and gives long-term protection

'Eraldin' is the only beta-receptor antagonist with the unique *safety factor of cardioselectivity.*

Eraldin

PRACTOLOL TRADE MARK

Detailed information is available on request.

ICI Leaders in Cardiovascular Research

THE QUEEN'S AWARD TO INDUSTRY 1966 1967 1968 1969 1970

Imperial Chemical Industries Limited, Pharmaceuticals Division, Alderley Park, Macclesfield, Cheshire.

PH 723/B

cakes, biscuits, etc., rather than ordinary flour which contains a fair proportion of protein. Fat, sugars, fruits and vegetables not only supply the essential calories, but also give bulk, taste and variety to the diet, and a number of ingenious recipes have been devised to this end, for unless sufficient food of the right type is taken, loss of body weight will occur, together with a rise in the level of blood urea, anorexia and nausea. On this highly restricted diet, now generally known as the modified Giovanetti diet, adequate amounts of vitamins cannot be given by food alone, and supplements are necessary for patients on this régime for any length of time. In individual cases restriction of sodium, potassium or both may also be necessary.

Regular Haemodialysis

When a patient receives regular haemodialysis, a rise in the level of blood urea, sodium, potassium and fluid will occur in excess of that which can be removed by dialysis unless some dietary restriction is continued. For most adults 60 g. protein per day is adequate and generally suitable. This allows for an egg at breakfast, two reasonable meat meals and milk for tea during the day. Salted foods, salted cheese and salt at table should be avoided, and only small amounts of salt used in cooking. If, in spite of these precautions, hypertension persists, all salt in cookery should be avoided. If there is a tendency to potassium retention, the dietary intake must be reduced by avoiding foods high in potassium, so that a dangerously high level does not build up between one dialysis and the next.

Most people have a general idea as to which foods are highly salted and which are not, but unfortunately, neither taste nor appearance serve as any guide as to the potassium content of a food. Adequate instructions about this have to be given to patients or their relatives in order to avoid excessive retention, which could lead without warning to cardiac arrest. Salt and fluid retention are generally more easily recognised by a feeling of being "water-logged," but the amount of fluid allowed can easily be exceeded if large amounts of gravy, fruits or fruit juices are taken.

Transplantation

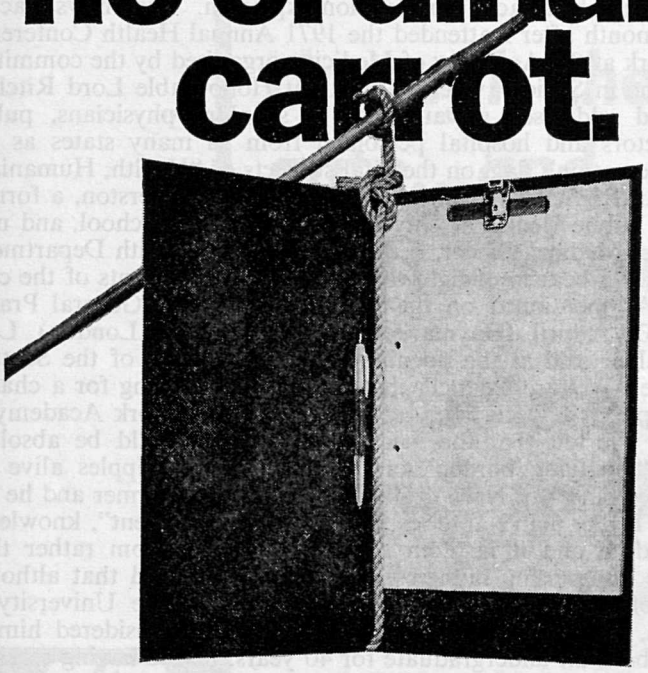
Whenever possible, a patient undergoing renal transplantation should be in a good state of nutrition before operation. With adequate dietary control his body weight, blood urea and electrolyte levels should be within reasonable limits, and this diet continued until the day of transplantation. After successful transplantation, with good renal function, no dietary restrictions should be necessary.

GUY'S DIARY

OCTOBER

12	Tu	1.00 Clinical Lecture.	Dr. KNIGHT.
15	F	2.15 Combined Round.	**LORD BROCK will present some cases.**
18	M	1.00 Clinical Lecture.	Mr. MAYNARD.
19	Tu	1.00 Clinical Lecture.	Dr. MANN.
21	Th	1.00 Clinical Lecture.	Mr. GLOVER.
22	F	2.15 Combined Round.	Dr. OGG will present some cases.

STUDENTS! This is no ordinary carrot.



This notebook cum folder cum writing pad cum penholder is Barclays free gift for students who open an account with us in 1971.

No bank charges for you, either, provided you keep your account in credit. Call in soon.

BARCLAYS

a good bank to get behind you.

Towards a National Health Service in the U.S.A.

Henry Windsley, M.B., B.S.

The raging cholera epidemic in West Bengal has sent out its S.O.S. to the United Nations in New York for medical aid and supplies. As this city is bathing in the spring sun, a torrential monsoon rain has brought about the scourge of a new plague in another part of the world. Once more multiple human aid societies are mobilised to pour money, personnel and medical supplies into India and Pakistan, to alleviate human suffering. All this is taking place in a continent which faces a population explosion. Such news reaches us only a month after I attended the 1971 Annual Health Conference in New York at the Academy of Medicine organised by the committee on Medicine in Society, where The Right Honourable Lord Ritchie-Calder had addressed an audience of scholars, physicians, public health doctors and hospital personnel from as many states as the stars on the nation's flag, on the vital subjects of "Health, Humanism, and Human Rights". Together with Dr. John Brotherston, a former teacher of Public Health at Guy's Hospital Medical School, and now acting Chief Medical Officer, Scottish Home and Health Department, they brought a beacon of light to a thousand participants of the conference. As mentioned on the front page of the "General Practitioner," 30th April (Haymarket Publishing Ltd., London) Lord Ritchie-Calder said at the opening of the conference of the Scottish Old People's Welfare Council, that he would be calling for a change in the Hippocratic Oath when addressing the New York Academy of Medicine. He felt that the medical profession should be absolved from the "terrifying burden" of keeping mental cripples alive by modern medicine. In New York, the climate was warmer and he felt and said "Today man's abilities far exceed his judgment", knowledge is not wisdom and it is often pruder to have wisdom rather than knowledge in assessing human values. He mentioned that although a holder of an M.A. degree by examination of the University of Edinburgh, he never sat an examination, but he considered himself as having been an undergraduate for 40 years, before having received the privilege of the degree. The former professor of International Relations of his University certainly captivated the Americans' hearts as a ripple of laughter passed through the audience on his Scottish wit. He remarked that it was thanks to the profession he is addressing that he owes his life, when at the age of 37 he was stricken by a serious illness. He stressed that although we possess all the instruments of precision to time a nuclear explosion, we have none to equate a population explosion in the future. Dangers might arise out of this in countries such as India, where the reproductive span of life has increased as the result of advances in Medicine. Two-thirds of the world is inadequately fed and still people breed like rabbits and have to die like rabbits! In this bio-engineering age, responsibility of health rests with the M.D., who also should see that Man is not a mere

Follow the trend at GUYS!

through the gate...and cross the road...

a complete service to the dental student

Claudius Ash
Sons & Co. Ltd.

living museum piece kept alive by an artificial kidney and some other artificial machine to take over the function of a human organ. Man has the right to live and die in dignity! He ended his address by a warning to the profession not to comply to divine book-keeping, not to say that it is the will of God today that life is three score years and ten; religious principles have to advance sensibly with the progress of science.

When I met Lord Ritchie-Calder privately at the reception subsequently, he took a great interest in some of the work that is connected with the advancement in community care at Guy's Hospital, and as a member of the Metrication Board, he was an eager listener for new thoughts. The meeting was Chaired by Dr. Joseph Post, Chairman of the Conference, who subsequently extended personal hospitality to me and whose guest I was for a day at his medical unit at the New York University School of Medicine and Bellevue Hospital.

On the following morning, amongst the panel of speakers were Robert E. Patricelli, Deputy Under-Secretary for Policy Co-ordination, Department of Health, Education and Welfare, Washington, D.C., and Hon. Edward Kennedy, U.S. Senator, Massachusetts, Chairman, Sub-committee on Health of the Committee on Labour and Public Welfare, Washington, D.C. Mr. Patricelli compared his job to that of a Dean who, when asked what his duties were, replied, "I perform the same function as a fireplug does to a dog." When going to work in Washington, he regarded it in a similar way, the only difference being "a larger fireplug to a larger dog." He emphasised that dealing with the question of "National Health Insurance Proposals; Leverage for Change?" will open him to contradictory statements, because of the narrowness of the subject matter. He stated that "there is a general consensus in Washington that there is a crisis in health care and a need for major reform in the United States." The hearings at Capitol Hill conducted by Senator Kennedy are playing a major role in communicating the disposition for reform to benefit the public and medical care providers. There is a considerable agreement on techniques that must be pursued towards a National Health policy. Prepaid group practice appeared to be the most promising vehicle for transmitting an efficient health care system. He emphasised the need for more physicians and health personnel and the provision for Federal funds to build more Medical Schools and satellite health education centres, especially in rural areas. The administration will have to face many problems to provide uniform health care and provide suitable inducements for doctors to practice in under-doctored areas which appear less attractive.

Dr. John Cotton, Director of Psychiatry, St. Luke's Hospital, New York, introduced Senator Kennedy in the focus of movie cameras and scores of Press photographers, with the gates to the hall guarded by special detectives and attendants. To the accompaniment of roaring applause, Senator Edward Kennedy ascended the speaker's rostrum and showed his enthusiasm to his audience in his willingness to answer questions after his address. He thanked the scholars, doctors of Medicine and Hospital administrators for the privilege to

address this distinguished audience at the New York Academy of Medicine, which represented for more than a century the best of American medicine. He stated "that there is need for reform in the health care system in the United States". "The major goal of our democratic society must be to ensure that all people should have assurance in getting an equal opportunity for a high quality of health care". The availability of health care is one of human rights, it should not be guided by the ability to pay. He stated: "Although we are the richest nation for winning Nobel prizes, we are winning no Nobel prizes for translating the laboratory discoveries into the realities of life. There is a soaring cost in health care and it is rising twice as fast as the consumer price index. We are now spending 70 million dollars for health, in 1974 it will be 100 million and by 1980, 200 million dollars. Health care in America is still a cottage industry. The doctors cannot change the system alone."

There appeared in his speech evidence of insufficient idealism in the calling of the doctor in the United States as helping the needy, deprived of health and unemployed as the result of incapacity. The financial reward is still a major attraction for doctors to congregate in affluent places and established towns with a high medical reputation. He criticised private insurance schemes for not taking sufficient interest in people's requirements for adequate coverage.

There is no doubt that the Health Insurance Bill he plans to put in front of Congress will produce many arguments, but it will become the milestone of the future health services in the United States of America.

Thomas Guy

The face above is seen in the hospital every day but does he represent the image of the sort of man Guy's wants at the moment? Our fashion correspondent, Philia, writes: "The brave roman face is appropriately set at counterpoint with the romantic sea swell of hair curling, nonchalantly abandoned, over his Cambric shift. His loosely tied scarf and frock, with a collar of the type re-introduced by the Beatles only ten years ago, make this man surely an outstanding example to the young medical man of fashion."

C. D. Beamish, who lately opined that medical students looked too little like city gents and far too much like, well, medical students, would perhaps do well to consider the appearance of our founder and benefactor. Or perhaps we should recognise that Thomas Guy's appearance in the statue, since he should be a source of visual inspiration to us all, should be attired in fashionable dress appropriate to the age he lives in? He would look well in pin-striped suit and a bowler hat.

NOTICES

The Blues Committee

There will be a meeting of all full blues on 25th October, at 5.30 p.m. in the Committee Room of the East Wing.

Theatre Club A.G.M.

The Annual General Meeting of the Theatre Club will be held on Thursday, 14th October, at 5.30 p.m., in the North Common Room, East Wing. Cheese and wine will be available afterwards and anyone will be welcome.

NURSING SECTION

WHO SHOULD TEACH IN THE WARDS?

One of the most frequent complaints which one hears made about Ward Sisters nowadays is their failure to teach the student nurses, and upon them is placed a large portion of the blame when examination results are not of a high standard.

Whereas nobody would deny that the Ward Sister does have a great responsibility towards teaching, it seems that there are probably a number of very good reasons why she may be unable to fulfil this task conscientiously. Moreover, if the difficulties were considered in depth, then it might prove possible to assist these people. Perhaps then, it is worth eliciting some of these.

One point should first of all be clarified. The average Ward Sister considers her most important function to be the care of patients. To this first priority everything else takes second place, including formal teaching of the nurses. One aspect, however, appears to be frequently overlooked. That is the fact that a trained nurse is teaching all the time by the way she works. Apparently this is not thought by tutors or students to be the case. Teaching, it seems, can only be labelled as such when the taught are sitting either in a circle or behind desks, and the teacher sits or stands in front of them. This, of course, is a very poor hypothesis, teaching is a continuing process which can be accomplished by the student using the powers of observation. Unfortunately though, this appears to be no longer a requisite of the good nurse.

However, for the purposes of the article, formal teaching will be the point of referral. Why then is this so difficult?

First, of course, there is the old enemy, staff shortage. One cannot, of course, hold classes when there is much work to be done. In addition, when a percentage of the nurses disappear daily for three hours in order to have lectures away from the wards, it is inevitable that the others will suffer and have to forgo the luxury in order to complete the work of others.

Next, let us look at the work of the Ward Sister. She also is supposed to work only 42 hours a week. In addition to being constantly required by the Medical Staff, and innumerable telephone calls, she has such tasks as stores ordering, and ward reports to write. Very often she has to remain on duty late to complete these because she has taught the nurses for one hour during the day. Should this be the case?

Moreover, nowadays many of the Sisters are themselves only just beyond the student stage. They receive very little practical help from those with more experience. They are frequently extremely worried by the prospect of teaching, particularly if they are made to feel that they must do this for one hour every day come what may. Should they not have a day off sometimes? Why do not tutors and administrators give classes in the wards? Not only would this be of practical benefit, but would in itself teach the Ward Sisters.

One argument frequently presented for Ward Sisters having more time for teaching is that many non-nursing duties have been removed. This is, of course, a false statement. What is a non-nursing duty? When analysed it transpires that there are very few. The Sister is the person who makes the decisions and co-ordinates the workers. In fact, it would seem that she has more than enough work to do.

Why is not more assistance given to the Ward Sisters regarding teaching? Surely tutors do not teach solidly all day every day. Why do they not go to the wards? They are, after all, qualified to do this specifically.

Surely in an average hospital there are sufficient qualified nurses to assist in removing the onus of teaching from being almost the entire responsibility of the Ward Sisters? In fact, it is actually a little surprising that a grade for this has not been invented, and that the Sisters are actually allowed to teach at all in these days of specialisation!

It does, however, seem unreasonable that they have to accept the burden unaided. Is it not time that serious thought was given to the problem instead of subjecting these people to a constant barrage of criticism without any constructive action? Does not the saying that "if a system does not work then there is something at fault with it" hold good in this instance?

In the York Clinic

"Herr Doctor Jones, I have here a case that I think you will find very interesting indeed in room 303."

"Very well, Dr. Krausmeyer, show me the way."

"Well George, how are you feeling today?"

"Just great. Who's that with you? Please ask him to come in. My house is always open. How do you like my new Van Gogh? I got it on approval, only I thought that it might clash with my Rembrandt. Please excuse the mess, I had a few friends round last night. At least they didn't spill anything on the billiards table. Why don't we go out on to the sun porch. It's a shame to waste such a beautiful day. Then again, most of the days here on the Riviera are, don't you agree? How about a round of golf on my private course after the luncheon. Ahhh, what a life of luxury. Not a care in the world!!"

"Herr Doctor, I think you'll agree with me that this case is . . . Herr Doctor, where are you going with those bags?"

"I'm moving in with him. He's on to a good thing."

P.N.L.

CORRESPONDENCE

Nursing Experience for Housemen

SIR,—Perhaps Nurse Reid (*Gazette*, 11th September, 1971) would care to make a few suggestions as to what up-and-coming housemen might write in the "column blithely headed 'Nursing Care'." This would then rapidly make up for the lack of nursing experience of doctors already qualified, and also obviate the need for students still in training to undergo the inconvenience of working solidly for four weeks.

Yours etc,

M. ST. G. WHEELEY

East Wing,
Guy's Hospital,
London, S.E.1.

Nurse Training on the Wards

SIR,—The leader in *The Nursing Times* of 16th September must have given many ward sisters much to think about.

Referring to the employment of junior ward sisters the question which needs answering is "What have those nurses in power posts been doing to allow the staffing situation in so many hospitals to get so far out of control that the gap had to be filled at any price?" That the situation is with us says little for the reforms which nurses in control have implicated since the hospitals were nationalised. The reforms were meant to bring in a golden era for nursing but they seem to have fallen disastrously short of the mark.

Regarding the matter of the ward sisters teaching, this seems a retrograde step when today the training of infants has to be undertaken in schools by qualified teachers. The thinking which directs that sisters qualified to nurse but not to teach should do so in a haphazard manner only when there is time to spare for it must be seen in a very poor light. That ward teaching today is inadequate and that basic repetitive nursing tasks in the ward are still being done in the primitive way they were done 50 years ago shows what little imagination and original thinking has been brought to bear on the subject. No firm in industry could afford to waste labour in like manner, neither would their employees submit to using such outdated methods. There is abundant evidence that nurses in control are determined to stick to traditional methods and that any suggestion which means altering these methods can expect to be stubbornly resisted and ignored. It is this attitude towards change which is restricting modern ideas being introduced into the ward work, and until such time as this approach is altered there is little hope of improvement in the number of trainee nurse failures in examination and, what is more important, in the student wastage, most of which takes place in the first few months in the wards.

There is now hope, however, that the young ward sisters, backed up by their medical colleagues will, if allowed, bring imagination and original thinking on to the ward floor. Perhaps it has not to be wondered that their older colleagues who trained 20 years ago under the rigid system of nurse training corporations have been unable to do this.

Yours faithfully,

MARY GRANT.

Albury,
Surrey.

NOTICES

Guy's Hospital Annual Dental Ball

To be held at the Grosvenor House Hotel, Park Lane, WC1, on Saturday, 6th November.

Tickets now available from Graham Brown and Subrette Smart.

Price £6.80.

Guy's Hospital Society, Bournemouth and Wessex.

The Sixteenth Annual Dinner of the Society will be held on Friday, 12th November, at the Norfolk Hotel, Bournemouth.

Dr. Malcolm Tuddenham will be in the Chair and the Guest of Honour will be Jimmy Goodliffe. It is hoped that more people will give the society their active support than did so last year, since there is a strong feeling that it should not be allowed to lapse.

The dinner, to which medical and dental guests are welcome, will be at 8.15 p.m., preceded by the Annual General Meeting at 7.30 p.m. Dinner jackets will be worn. The cost of the dinner is £2.50.

Members who wish to attend are asked to notify E. H. Archard, Hon. Secretary, not later than Friday, 5th November, and to include names of guests to assist in the seating arrangements.

It would be helpful if members would remit their annual subscription of 50p at the same time.

Special Problems in Paediatrics

The British Postgraduate Medical Federation will hold a Week-end Course in Paediatrics, for General Practitioners and Local Authority Medical Officers, entitled "Special Problems in Paediatrics." It will take place at the Evelina Hospital on Saturday, 30th October, and Sunday morning, 31st October. Applications for a place in the course should be made to the Hospital Secretary, Evelina Children's Hospital, Southwark Bridge Road, London, S.E.1., as soon as possible.

SPORT

This week, Guy's has the pleasure of welcoming not only a large number of medical and dental students but new radiographers, physiotherapists and nurses.

In the past many folk of these latter groups have felt that they were perhaps not welcome to participate in the sports activities of the hospital. If this has been the case in recent years it certainly is no longer and it is fair to say that the sports clubs, without exception, are looking forward to receiving new members from every section of the hospital. From the new students' point of view there are many advantages to be gained from joining the Guy's sports clubs, perhaps the most important of which is the opportunity to meet their fellow students old and new.

Guy's has been able to put out teams in sports ranging from rugby, hockey, water polo all the way to table tennis which have been able to match any from the other London Colleges and on occasions have had sides well up to the standard of the best in the country.

New and keen support is essential if we are to maintain this kind of sporting record.

RUGBY

The Ist XV have started the season a little unsteadily with victories over the Old Askeans and Bromley but being soundly defeated by the senior sides of Blackheath and U.S. Portsmouth.

Despite a good solid pre-season training period, ably led by this season's new captain, Carter Croft, the side has just not "clicked". Possibly one of the most significant factors is the absence of some of last season's regular Ist XV who as yet have not returned from the summer vacation for the new term; however, this problem will soon be solved.

Once the Ist XV begin to "play together" and harness the exceptional talent of certain players there is no reason why they should not be able to go through a season as successful as last year's when they brought home the Hospitals' Cup.

GUY'S v. OLD ASKEANS

Kidbrooke, 25th September. Result won 10—9.

Guy's gained their second win in three games by beating Old Askeans by 10 points to 9. Guy's were lucky not to be down after the first 20 minutes when the referee awarded six kickable penalties against them all of which were missed. Meanwhile Novak kicked a good penalty from 40 yards for Guy's.

Guy's then found their form and were producing good moves from loose play. The forwards combined very well together but the backs were unable to finish off some good chances. It was up to Novak again to provide the rest of the Guy's points. First he kicked another fine penalty, then forced his way over for an unconverted try. Thus Guy's were able to change round at half-time ten points in the lead.

In the second half the pack continued to provide some good opportunities for the backs. The back row of Holliday, Novak and Fallowfield worked well at times. The centres seemed unable to penetrate the Askean defence despite the chances presented to them. Barough made some good thrusts from defence down the right wing but had little to do in attacks from set moves.

Meanwhile Askeans came back into the game with a penalty and a converted try under the posts. Nevertheless Guy's completed a well-deserved win by a narrow margin.

Team: 1. D. Stuart, 2. T. Gibson, 3. J. Rosewall, 4. R. Burt, 5. R. Massey, 6. A. Fallowfield, 7. H. Holliday, 8. M. Novak, 9. C. Croft, 10. M. Mahoney, 11. R. Barough, 12. A. Campbell, 13. T. Druett, 14. D. Armstrong, 15. J. Rees.

HOCKEY CLUB

Results:—

	Played	Won	Drawn	Lost	Goals For	Goals Against
1969—70	29	14	10	5	60	28
1970—71	32	13	8	11	28	29

This club deservedly enjoys one of the best reputations amongst the London Colleges. The results for the past two years show a fair number of wins but last season far too few goals.

The club has won the University Inter-College Cup for the last three years. The Inter-Hospitals Cup has been shared once and the side were runners-up last year. But the results against the top clubs have been getting worse, mainly due to lack of talent. Last year the number of freshmen joining the club could be counted on one hand and a strong contingent of new recruits is needed if the traditional four sides are to be got out.

The freshers trials will be on the first few Wednesdays of the term, and the teams for Saturdays will be put on the notice board in the East Wing. There is no need to be put off by the thought of regular training because you can still get a good game on the Saturday without playing any hockey mid-week. As with all the other clubs there is a chance to meet students other than those in one's own intake.

To end the season there are two Easter tours which cost very little. For the 1st XI a semi-serious festival at Folkestone and for the Spirochaetes (the Sunday side) a few good days at Paignton in Devon.

So the Hockey Club offers a strong fixture list to tempt the ambitious, and the opportunity of playing for United Hospitals on Sundays. For someone who wishes simply to keep fit it offers outstanding sociability.

If you are interested please contact either: P. Calvert, Captain; R. Burns, Vice-Captain; P. Nicol, Fixture Secretary; or J. Cottingham, Team Secretary, by leaving a note in the pigeon hole or on the message board.

R.W.B.

SQUASH RACQUETS

Although the Squash season officially starts in October, the Squash Club has already been active for some weeks. Indeed some players have been playing throughout the summer, in places as far apart as Gibraltar and Beaconsfield (wherever that is!).

At last season's A.G.M. it was decided that the courts needed cleaning. Visiting teams had been telling us how dirty they had become, while we were rather used to playing in the gathering gloom. In fact, it was quite an advantage to play on courts where only the home team could see the ball!

The captain, while reading his journals, noted that one of the largest clubs in the country used Ajax to clean the walls of the courts. We elected to do likewise. I must thank Tony Edwards for experimenting with the Ajax, borrowing the buckets, rags, scrubbing brushes, ladders, and scaffolding, for obtaining new lights and, subsequently, for organising the repainting and replastering.

I was left to recruit "volunteers" and was extremely unsuccessful. However, I would like to thank the few (about eight) who did help out. I only hope that they have recovered from the attacks of housemaids' knee and scrubbers' elbow, which plagued most.

With the courts clean, we were able to start practising. The first session was notable only for the general lack of fitness (Ray Sharp excepted). Jerry Owen looked as though he was still on his honeymoon and Ian Harrison hadn't got over the shock of becoming a father. However, things have improved and prospects for the forthcoming season are excellent.

Squash Teams

Any student who would like to be considered for one of the Squash teams should leave a message in the squash pigeon-hole in the East Wing.

Ladies' Squash

The Ladies' Squash section has been resurrected. Any lady interested in playing squash should either contact Rosemary Cotton (in the School of Physiotherapy) or turn up at the practice on Tuesdays at 4.15 p.m.

Singles Tournament

This is open to medical and dental students. Would anyone wishing to enter please write their name on the list on the Squash notice board (opposite the students' bar). Closing date for entries—20th October.

Equipment

I would remind players that gym shoes with white or natural rubber soles must be worn for Squash. Dark soled shoes must not be worn as they mark the floor.

The Squash Club cannot lend equipment. We recommend players to buy their "kit" from John Bennett and Co., 157-163 Old Kent Road. A 10 per cent discount is available, on production of a Clubs' union card.

E.J.E.

HOSPITAL INFORMATION

GUY'S HOSPITAL
HOUSE APPOINTMENTS
1st December, 1971

Applications are invited for the following house appointments due to begin on 1st December, 1971. Forms of application are obtainable from and should be returned to Mrs. Webster, Administrative Assistant for Medical Staffing, not later than **20th October, 1971.**

The following house appointments will be for six months and normally will be open only to pre-registration candidates applying for their first appointment and not to candidates seeking their second six months' appointment:—

House Physicians 3
House Surgeons 3
Throat and Ear House Surgeon 1
Gynaecological House Surgeon 1
Orthopaedic House Surgeons 2
(The successful applicants will be required to spend six weeks at New Cross Hospital.)

The following house appointments will be for six months and will be open to candidates who have already completed their first six months' appointment at Guy's or elsewhere:—

House Physician 1
House Surgeon 1
Children's House Physician 1
Genito-Urinary House Surgeon 1
(or post-registration)
House Surgeon to the Thoracic Unit .. 1

The following post-registration and S.H.O. appointments will be for six months:—

Resident Obstetrician 1
(S.H.O.)
Casualty Officers 3
(S.H.O.)
Resident Anaesthetists 2
(S.H.O.)
Senior House Officer to Nuffield House .. 1
(S.H.O.)
House Physician in Child Psychiatry .. 1
(post-registration)

EVELINA HOSPITAL

Children's House Physicians 2
(post-registration)
1 to commence 1st December, 1971.
1 to commence 1st February, 1972.

ST. OLAVE'S HOSPITAL

House Physician 1
(pre-registration)
(Preference given to second 6 months candidate).
House Surgeon 1
(pre-registration)
(Preference given to second 6 months candidate).
Senior House Surgeon 1
(S.H.O.)

NEW CROSS HOSPITAL

House Physicians in General Medicine with Rheumatology and Geriatrics 2
(pre-registration)
(Preference given to second 6 months candidate).

OUTER HOSPITALS

Preference will be given to second 6 months candidates for the following posts, but first 6 months candidates may apply.

HITHER GREEN HOSPITAL

House Physician in General Medicine and Infectious Diseases 1
(pre-registration)

GREENWICH DISTRICT HOSPITAL
(married accommodation available)

House Surgeon with E.N.T. to Mr. O'Flynn, Mr. Wilson, Mr. Hollis and Mrs. Wengraf (pre-registration) 1
House Physician to Dr. Mallinson (pre-registration) 1
House Surgeon—3 months urology and opthalmology followed by 3 months general surgery with Mr. Eldin 1

LEWISHAM HOSPITAL

House Physician to Dr. Price
(pre-registration) 1
(possible locum from 12—30 November)
House Physician to Dr. Roberts
(pre-registration) 1
House Surgeon to Mr. Ivo Smith
(pre-registration) 1
House Surgeon to Mr. Lynn Evans
(pre-registration) 1
House Surgeon with Orthopaedics to Mr. Monty, Mr. France and Mr. Bingold .. 1
(possible locum from 15—30 November)

MILLER GENERAL HOSPITAL

House Physician to Dr. Hartley, Dr. Bassadone and Dr. Mallinson
(pre-registration) 1
House Surgeon to Mr. O'Flynn
(pre-registration) 1

ORPINGTON HOSPITAL

House Surgeon with Orthopaedics to Mr. Boxall and Mr. Lam 1
House Surgeon with Gynaecology to Mr. Boxall and Miss Austin
(pre-registration) 1
House Surgeon with E.N.T. Surgery to Mr. Walker Brash and Mr. Rainer
(pre-registration) 1

House Surgeon with Dental to Mr. Boxall and Mr. Macdonald
(pre-registration) 1

PEMBURY HOSPITAL

House Surgeon
(pre-registration) 1
House Physician
(pre-registration) 1

ST. NICHOLAS' HOSPITAL, PLUMSTEAD

House Physician to Dr. Scott
(pre-registration) 1

ST. HELEN'S HOSPITAL, HASTINGS

House Physician in General Medicine and Geriatrics to Dr. R. Irvine
(pre-registration) 1

P. J. HELLIWELL,
Superintendent.

September, 1971.

PERSONAL

ASSISTANT/ASSOCIATE required in large single-handed dental practice central Brighton, owned by Guy's man qualified 1956. Two fully equipped surgeries in use now. Two spare rooms available for surgeries. Tel: BRI 61544.

GUY'S MAN urgently required in 4-surgery dental practice, Rochester, Kent. Associateship, good commission. I.V. practised, lab. on premises. Contact C. T. Brooks, 1 Esplanade, Rochester, or Tel: Medway (OME4) 41337.

CHANGES OF ADDRESS

Dr. and Mrs. Peter Bishop to Moorhaven, Bovey Tracey, TQ13 9HE, Devon. Tel: Bovey Tracey 3264.

Dr. and Mrs. T. E. C. Bushell, 15, Harrogate Court, High Street, Langley, Bucks. Tel: Slough 44853.

Dr. John E. Davies, Winch Lane Medical Centre, Haverfordwest. Tel: 3693.

Jill A. Dixon, 17, Orchard Way, Haywards Heath, Sussex. Tel: 0-444-51201.

Dr. and Mrs. Charles Marshall, Cranham, 18a, Church Hill, Pinhoe, Exeter, EX4 9JQ. Tel: Exeter 66489.

Dr. and Mrs. J. F. Murray, 119, London Road, Forest Hill, London. Tel: 01-290 2048.

Dr. and Mrs. E. M. Newton, Netherfield, Round Street, Cobham, Kent. Tel: Cobham 247.

BIRTHS

AYNSLEY-GREEN—On 28th September, in the Radcliffe Infirmary, Oxford, to Rosemary (née Boucher) and Albert Aynsley-Green, a daughter, Victoria Louise, sister to Sarah Anne.

HALL—On 23rd July, 1971, to Rosemary (née Baker) and Stephen, a son, Jonathan Rupert, at the Royal Sussex County Hospital, Brighton.

ORME-SMITH—On 11th September, to Ann (née Ridley) and David Orme-Smith, a son, James Donal, brother for Sarah, Charlotte, Paul, Lucinda, Victoria and Sophie.

LATHAM—On 10th September, to Carole (née Mawson) and John Latham, a son, Richard Peter, a brother for Amanda and Michael. Address: Roundway House, The Roundway, Rustington, Sussex.

MARRIAGES

DAVENPORT—LANGE—On 30th August, 1971 at St. Paul's Church, Mill Hill, Dr. Peter Davenport to Dr. Sarah Lange.

DEAR—BURROWS—On 25th September, 1971 at the Parish Church of St. Peters, Stourhead, Wiltshire, Michael George Dear of London to Shirley Louise Burrows of Vancouver.

PAPERS BY GUY'S MEN

Batchelor, J. S. Congenital hip dislocation. *British Medical Journal*, 1971, **3**, 535.

Cameron, J. S. Proteinuria. *In Seventh Symposium on Advanced Medicine*, at the Royal College of Physicians of London, February 1971; edited by I. A. D. Bouchier. p.276. Pitman, London, 1971.

Fraser Roberts, J. A. Genetics in medicine: the Lumleian lecture. *In Seventh Symposium on Advanced Medicine*, at the Royal College of Physicians of London, February 1971; edited by I. A. D. Bouchier. p.106. Pitman, London, 1971.

Hunter, Donald. Occupational diseases. *British Journal of Hospital Medicine*, 1971, **5**, 67.

Polani, P. E. Errors of sex determination and sex-chromosome anomalies. *In Seventh Symposium on Advanced Medicine*, at the Royal College of Physicians of London, February 1971; edited by I. A. D. Bouchier. p.66. Pitman, London, 1971.

Usiskin, L. A. and others. A comprehensive treatment of the severe Class II, Division 1, malocclusion. *Dental Practitioner*, 1971, **21**, 437.

We would like to remind our readers that all copy for inclusion in the "Gazette" must be received eight days before publication date.

Copy may be sent to us c/o The Front Lodge, Guy's Hospital.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, please indicate whether or not this should be published.

Personal notices 5p per word (pre-paid) (minimum £1.05).

Non-subscribers will pay £1.05 (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

EDITOR A. M. TURNER
NEWS EDITORS C. G. CHINERY and D. I. F. KELLEHER
SPORTS CORRESPONDENT A. M. ROYSTON
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TEN PENCE VOLUME 85 NUMBER 2173

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

18 Years after Kinsey

There is a story from the unenlightened past about a judge who was examining the case of a man accused of raping a young girl. When the judge heard of the accused's previous conviction for homosexuality he said, "Well, at least this is a step in the right direction." Recently we have read reports about the police in several cities drilling spy-holes in the ceilings of men's public lavatories to watch the possibly homosexual activities of the men in the cubicles. It is best not to explore the personalities of the men who spend their time in such vigilant pursuits, let us hope that they are not happy either. It is, however, interesting to consider the general attitude of the society that has led its police to take a most attentive interest in the sexual practices of its members.

Most discussions on homosexuality start with the Socratic belief that love between two men creates a spiritual form of immortality, as opposed to the physical form produced by a man and a woman together; they achieved and created a beauty that never died. It is not important to dwell on that beyond comment that a society that was admirable in many ways saw that love between men could lead to self-fulfilment. An explanation of the behaviour more consonant with the present way of looking at differences was given, unsurprisingly, by Aristotle when he postulated an anatomical aberration of the erogenous zones.

Nowadays, with our modern technological techniques, we have evidence that if scientists play about sufficiently with the hormone levels of male rats during their development then they will look like males but adopt female postures, the rats, that is. We are still searching for a physical cause that will exonerate people from the responsibility, and perhaps even lead us to a cure, for behaviour that to the Christians in the Middle Ages was so horrible it had no name. It might seem a dead question to ask why we should want to correct the ways of men or women who prefer members of their own sex, but

we still only allow adults any expression of this preference in the comfort of their own home. Men or women showing homosexual affection in public, unless they are world leaders and astronauts, invite public disgust. Yet statistical studies show how high is the prevalence of people who admit to experiencing physical homosexuality at least once. The figures vary but seem to be between 15 and 25 per cent. Yet we still regard such behaviour as abnormal and look for scientific reasons, for a cause. When does something need a special cause? Heterosexuality is then presumably a behaviour pattern that has one thing that we can give the category of cause. The effect the experience has had on the population is not to accept homosexuals but to pity them, to want to cure them, to loathe them, or to fear them. If the experience is so harmful it seems strange that people who are now trying to cure others of their error and punish them for it are now such perfectly balanced, healthy individuals. Now it is true that many people exhibiting homosexual behaviour come to their doctors asking for help, and they suffer from a variety of complaints ranging from organic brain disorders to problems of personality adjustment from an early age. But there are many people of homosexual and mixed sexual behaviour that are as happy with their life as anyone else is.

It would seem that the extreme reaction to homosexuals stems from a fear that the behaviour might affect other people, or the people they love; that the behaviour might attract and that would disturb the order of things, the order that gives so much trouble but is the only one we have and it would need a great deal of effort to devise one for ourselves. The continuing attitude of society, it seems, is one that derives from an ambivalence of attraction and fear, but does not stem from the rights or wrongs of the practice.

GUY'S DIARY

OCTOBER			
25	M	5.30	The Scientific Basis of Medicine*. Professor CRANSTOW. "Fever."
26	Tu	1.00	Clinical Lecture. Mr. BLACKBURN.
		5.00	*Clinical Medicine*. Dr. NORTHFIELD. "Acute Gastro-Intestinal Bleeding."
		6.00	Update*. Dr. HAMER. Electrocardiography.
29	F	2.15	Combined Round. Dr. McHARDY-YOUNG. "Multiple Endocrine Disorders."
NOVEMBER			
1	M	5.30	The Scientific Basis of Medicine*. Professor LYNE REID. "The *Bronchial Epithelium* in Disease."
2	Tu	1.00	Clinical Lecture. Mr. LEWIS.
		5.00	Clinical Medicine*. Dr. CLARK. "Acute Respiratory Failure."
		6.00	Update*. Dr. SOMERVILLE. "Congenital Heart Disease in Adults."
5	F	2.15	Combined Round. Dr. GRAHAME. "Some Rheumatological Rarities."

*Denotes that the programmes are televised and shown in the Anatomy Lecture Theatre.

The venue of the Combined Rounds has not been finally decided.

NEWS IN BRIEF

Dr. Philip Evans, Children's Physician and Director of the Department of Paediatrics since 1946, retired at the end of September. Dr. Evans was educated at Manchester University and graduated B.Sc. in 1930, and M.B. Ch.B. in 1933. After attaining M.R.C.P. in 1935, he gained a Rockefeller Travelling Research Fellowship and was Assistant Paediatrician to Johns Hopkins Hospital, Baltimore. He returned to England as Assistant Paediatrician to King's College Hospital and achieved M.Sc. and M.D. in 1941. He served in the Royal Army Medical Corps during the War and retired as a Lieut-Colonel. He was elected F.R.C.P. in 1945. His post-war distinctions include the editorship of the Archives of Diseases in Childhood and the Presidency of the Paediatric Section of the Royal Society of Medicine. He was visiting Paediatrician to the Children's Hospital, Saigon, in 1966-67, and was appointed C.B.E. in 1968.

We wish him a long and happy retirement from Guy's. Dr. Evans continues to practise as Physician to the Hospital for Sick Children, Great Ormond Street.

Surgical Take-in

Following a recent Surgical Meeting it has just been decided to change the take-in rota operating for surgical take-in.

The present system of one week continuous duty in four is to be changed to the medical system of one day in four on duty. Thus the firm taking-in on Monday will also do the following week-end comprising Friday, Saturday and Sunday.

The shortened system of take-in has proved satisfactory on the medical wards as it spreads the load better, and relieves the more junior members of the firm of seven sleepless nights in a row.

The new rota will start on Monday, 1st November, and the order will be:—

Mr. Blackburn,
Mr. Lawrie,
Professor McColl,
Mr. Glover,

repeating in this order.

The recently-issued Surgical Take-in Students' Rota will be modified accordingly and the Medical School will issue a revised rota as soon as possible.

BOOK REVIEW

BED RIDDANCE. A posy for the indisposed.

by Ogden Nash. Published by Andre Deutsch. 128 pp. £1.60.

It may be brash
To suggest
That Ogden Nash
(Below his best)
Could write trash.
This review
Took no time
And I'll show its true
With a silly rhyme.

To quote Abraham Lincoln (*J. clin. Invest.* 1834): "This is a book which people who like this kind of book will like". I don't and didn't.

M. S. R.

mps

medical protection society est 1892

Unlimited legal aid and indemnity against professional hazards throughout the world (except U.S.A.)

Secretary Dr. H. A. Constable. Head Office
50 Hallam Street, London, W1N 6DE. Tel: 01-580 9241
or Regional Secretary Dr. P. G. T. Ford
Regional Office: 30 Park Square, Leeds 1. Tel: 0532 42115-6

Casualty Project

Miss H. Holt and Miss F. Windle

Introduction

The Medical Social Work Department discussed the idea that two of their members might be able to undertake a study, which would be of use both to the Social Work Department and the Hospital. The study took place between the months of April and July, 1971, and half-a-day a week was set aside for this purpose.

It was decided that a valuable study could be made of the need for Social Work in the Casualty Department. The idea of doing a study in the Casualty Department was discussed with the staff concerned and it was with their help that we were able to carry this out.

The Casualty Department was chosen particularly, because from the large numbers of people coming in a crisis situation, there could be a significant proportion whose social situation is relevant to their medical situation or could be aggravated by it.

Aim of the Study

It was felt by the Social Work Department that the social needs of patients coming to Casualty were not often discovered (hence the small number of referrals). It was also felt that some patients may have social needs which might not necessarily be best dealt with by a Medical Social Worker, but by a Social Worker in the community for example, a local Welfare Officer. It was thought that many patients coming to Casualty would fall into categories that could be described as "at risk" and these were defined as the elderly, the disabled, mothers with young children, and people who had no fixed abode. These people, we felt, were the most likely to present themselves with problems in Casualty, and this is reflected by the type of referral we receive from the Casualty Department. It was from the people falling into these categories that we were trying to define the most appropriate form of Social Work help for Casualty.

Method

In order to sample the Casualty population, we arranged to spend each Thursday afternoon in Casualty for two months. It must be recognised that this method does not produce an entirely representative sample as it appears that different types of patients attend Casualty at different times.

We first of all did a pilot study (see Appendix I) by giving a trial questionnaire to Casualty patients and from this was decided that the questionnaire should be amended to include the patient's name, the ages of the other members of their household and we also found that it was necessary to give examples of social services in order that question 3 could be understood by patients (see Appendix II).

Having drawn up our final questionnaire for the next seven weeks, we gave these to every patient coming into Casualty between 2.30

AFTER GRADUATION . . .WHAT?

The newly qualified Dental Surgeon leaves hospital with a fund of professional knowledge, but generally ill prepared for putting this to the practice of earning a living.

The first assistantship is of paramount importance, with special emphasis on working with a Principal who can provide the right professional guidance and bearing in mind such essential matters as surgery conditions, remuneration, location and partnership possibilities.

LOCUMS LTD. specialize in launching young graduates into professional practice. Assistance to thousands of Dental Surgeons has been our business for many years. So consult Our Registrar today for free, friendly and helpful guidance. Ring—Write or Call:

LOCUMS LTD.

30 THURLOE STREET, SOUTH KENSINGTON, LONDON, S.W.7. Tel. 589 7292 (5 lines)

p.m. and 4.30 p.m. The questionnaires were given to patients as they registered with Casualty Reception. They were asked to complete them whilst waiting to see the doctor and to return them to the Reception Desk as they went out. This seemed to work satisfactorily and most patients were quite willing to co-operate. We obviously did not interview the emergency and accident cases as this did not seem feasible or appropriate.

As each questionnaire was returned, we then filled in the follow-up sheet (see Appendix III). The information required from Part A was obtained from the patient's Casualty card and gave more information about the person concerned, why he had come to Casualty and how his problems had been dealt with. It was then possible from this information to decide in which risk category, if any, each patient fell.

Patients who did appear to be at risk were followed up further to ascertain whether or not they were known to the Medical Social Work Department and, if they were admitted to hospital, we requested the medical notes of these patients to find out if they were subsequently referred for social work help.

Results

We analysed the completed questionnaire and follow-ups and the results were:—

Date	Total	K to S.S.	At Risk	At Risk K to S.S.	Losses
29.4.71	13	1	2	1	4
6.5.71	12	2	2	1	4
13.5.71	15	–	1	–	4
20.5.71	10	1	1	1	–
3.6.71	7	1	1	–	–
10.6.71	14	1	1	1	4
17.6.71	8	–	–	–	4

The results showed that out of the 79 people whose questionnaires were analysed, only eight or approximately 10 per cent were by our definition socially at risk. Only one of these people was known to the Medical Social Work Department, but four of the eight were known to Social Service agencies.

Conclusion

It would appear from these results that contrary to our original premise, very few of the people coming to Casualty could be considered "At risk" according to our definition. Only one of these patients was admitted to hospital and she was not referred to the Medical Social Work Department.

Further Analysis

The conclusions that we drew from our study were limited to our original definition of people at risk, and therefore not very comprehensive. We found, however, that with the help of a senior member of the department, we could broaden the scope of our study by breaking down the groups of people who did not fall into our "At risk" categories.

Earn £1,697 as a student and be a Naval Officer.

If you are qualifying in 1973 you're in the running for a Dental Cadetship. A guaranteed salary, all your fees paid and the rank of Sub-Lieutenant.

Then, on qualifying, you join us for a five year short career commission in a naval practice of your own.

We promote you to Lieutenant and your pay to nearly £3,000 a year.

And on top of this, you'll get a tax free gratuity of at least £1,400 at the end of your commission.

While you're at sea, you'll be responsible for the dental health of the whole ship's company. And if you're ashore, you may look after their families as well.

Wherever you are, you'll enjoy the travel and good company that a Naval Officer gets.

(As well as students, we also take on qualified dentists for three or five year short career commissions. They can apply on qualification.)

If you'd like to know more about the advantages of training and practising with the Navy, let us know your age and qualifications. And we'll send you a booklet and tell you how to get an interview. Write to: Surg. Cdr. (D) P. R. J. Duly, R.N., (26YA), Empress State Building, Lillie Road, London SW6.

RN
ROYAL NAVY

The total number in these groups for whom we had a fully completed questionnaire and follow-up was 51. These were broken down in terms of age, sex, repeated attenders in hospitals and those with the type of medical or physical condition which one might suspect is caused or aggravated by socio-emotional factors.

Results and conclusions.—

Men		**Women**		**Children**	
Age	No.	Age	No.	M.	F.
50's	5	70's	1	3	–
40's	6	60's	1	(ages: 7, 9, 4)	
30's	6	50's	4		
20's	11	40's	1		
Teens	6	30's	–		
	—	20's	1		
Total:	34				
	=	teens	6		
			—		
		Total	14		
			=		

From this analysis it would appear that, during the average afternoon, at least the majority of Casualty patients are young men, with a high proportion of middle-aged men and teenagers. It was noticeable that there were no elderly men and very few elderly women. There were also very few women in the age-group likely to have young children. Only one of these patients was known to the Social Services.

It was noticeable that the majority of these patients had attended Hospitals (Guy's or others) either as in-patients or out-patients, or casualties more than once and a significant number three times or more. Most of the causes for their attendance at Casualty were of the usual type, i.e. minor accidents, cuts and bruises, boils. However, the following patients were picked out as a group with less obvious potential problems. The number of these from each week's total is also given.

The group consists of teenagers (often with a large number of siblings who could be using their injury or illness as a means of seeking attention), middle-aged men and women with possible psychosomatic illnesses, and repeated attenders of all age-groups with complaints which could quite reasonably be suspected to have some psycho-social basis. It is suggested that those examples show the type of casualty patient who might have social problems with which the Medical Social Work Department could help.

It is this group who would require the services of a qualified Medical Social Worker rather than anyone else in order to diagnose the problem, if any.

The difficulty in meeting the potential need of such people is that the information on which these conclusions are based is not normally readily available to casual staff who cannot easily spot such cases to refer them for social help. It is interesting to note, however, that even very limited information can give a very good picture of the person coming to casualty.

Septrin
a story of success

decisive action
Bactericidal against a wide range of organisms, including *Proteus* sp, *E coli, H influenzae.* Double attack on bacteria substantially reduces the chances of resistant strains developing.

rapid response
Fast absorption from the gut to give peak plasma concentrations in 2-4 hours. Quick eradication of pathogens speeds the patient's recovery.

ease of treatment
Simple dosage regimen. Available in tablet and suspension forms.

Septrin
in bacterial infections

SEPTRIN* Tablets, SEPTRIN Adult Suspension, SEPTRIN Paediatric Tablets and SEPTRIN Paediatric Suspension contain trimethoprim and sulphamethoxazole. Full information is available on request.

* Trade Mark

Wellcome

Burroughs Wellcome & Co.
(The Wellcome Foundation Ltd.), Dartford, Kent.

Total	Number potentially at Risk	Age	Sex	Presenting Circumstances.
8	2	21	F.	Single. Rashes.
		30	M.	Referred for treatment to cut. Previous duodenal ulcer.
2	1	49	M.	Three injuries this year, fractured foot.
10	3	18	M.	Insurance Clerk. Four hospital attendances. Pulled ligament in knee.
		20	M.	Gastric cramp. Told by G.P. to give up smoking and drinking.
		16	M.	Eight siblings. Head injury.
9	2	17	M.	Eight siblings. Injured ankle.
		36	M.	West Indian. For treatment to cut sustained three days ago. Baby two weeks old.
6	2	44	M.	Many hospital attendances for anxiety neurosis.
		55	F.	Many hospital attendances. Lives with sister. Cyst removed.
10	3	49	F.	Constant dermatitis. Known by M.S.W. Dept. to be anxious about arthritic mother.
		15	F.	Cellulitis of feet. "In care" and lives in a hostel.
		16	M.	Repeated attendances for head injuries. Came in with headache following injury.
6	3	16	F.	Head injury—ex ward—returned next day with headache. Adopted sister.
		58	F.	Back trouble. Many hospital attendances. 28-year-old son living at home.

General Conclusion and Comments

Our overall impression of the kind of people coming to Casualty was not as we imagined. We expected to find Casualty frequented by old people, young mothers, and people with nowhere to live who might be greatly helped by a practical social work service. We hoped to discover whether this help would be most appropriately given by a Social Worker in the community or the Social Work Department in hospital. The kind of help we expected these people to need was, for example, for the elderly, meals on wheels and home help, for young mothers help with finding someone to look after their children and home whilst they are in hospital, for the "N.F.A." somewhere to live. We had imagined that over and above these particular patients with whom we might be able to help there would be a number of major accidents and acute illnesses brought into Guy's in an emergency whose problem would be more immediately a medical one, the atmosphere in Casualty as we imagined would be one of great excitement, activity and emotional tension.

In fact, we found the atmosphere in Casualty relatively relaxed and were surprised at the absence of fuss. The problem of each person was treated very much as an ordinary part of the day's work, and unless someone was brought in on a stretcher, each person received the same unhurried, calm attention.

Now Sensodyne gives the complete treatment for hypersensitivity sufferers.

Patients suffering from hypersensitivity often neglect oral hygiene simply because brushing hurts too much.

Now Sensodyne can break this pain/fear/neglect cycle.

The Sensodyne Softex brush used in conjunction with Sensodyne tooth-paste, makes brushing teeth a pleasure again.

The Softex tooth-brush has specially rounded bristles—no sharp points to scratch or injure gums. The bristles are close packed to give the most efficient cleaning action.

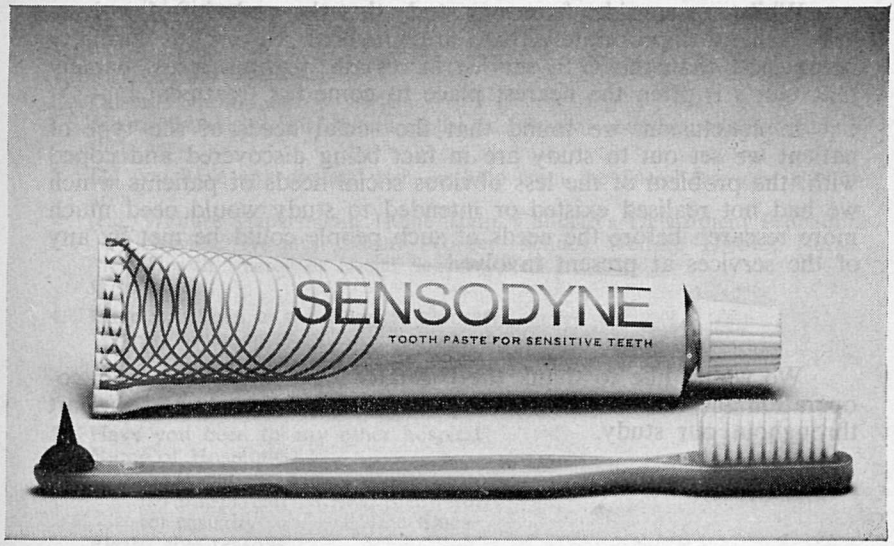
The head of the brush is short and narrow, making it easier to brush properly, and clean all parts of the teeth. And there's a special tip of natural rubber for extra gum massage between the teeth.

Sensodyne tooth-paste is specially made for the adjunctive treatment of hypersensitivity. It contains strontium chloride, a therapeutic agent with a cumulative de-sensitising action.

The more your patient brushes with Sensodyne, the less it hurts, so the habit of regular brushing is quickly regained.

The Softex tooth-brush and Sensodyne tooth-paste used together give the complete treatment for Sensitivity sufferers.

STAFFORD-MILLER
Quality products for dental health.



The obvious social problems that we had expected to find and which can, on the whole, be dealt with by a Social Work Assistant, are, in fact, referred to the Social Work Department. The small number of such referrals could be because as Casualty staff, say, problems arise outside the hours of 9.00 a.m.—5.30 p.m., especially among the elderly and the N.F.A's. It is, however, important to recognise that there is little that a Social Worker, were she available at these times, would be able to do. Casualty staff have considerable experience in dealing with these problems for themselves, it might therefore be useful for them to have more information available, especially on local community resources.

Although the more obvious social problems defined in our original four categories do appear to be fairly readily identified by Casualty staff and referred for appropriate help when possible, we have concluded from our further analysis that there is a definite group of Casualty patients who may have underlying social problems which they present as a medical problem and who use Casualty as a place of breakdown. Some such patients, but by no means all, may be the cause of the opinion held by some Casualty staff that Casualty is used instead of the G.P. service in that their presenting medical symptoms could be more appropriately dealt with by their own doctor.

However, it seems possible that these patients use Casualty because its anonymity means that their presenting problem can be attended to whilst they will not be required to face up to or seek help with their real problem. This sophisticated use of Casualty could be identified by a skilled Medical Social Worker and given more appropriate help. These patients' problems could be more fully appreciated and they would seem less of an inconvenience.

Whilst we consider from our study that the majority of patients use Casualty appropriately there are practical reasons for Casualty being used than the G.P. service in certain circumstances, namely that Guy's is often the nearest place to come for treatment.

In conclusion, we found that the social needs of the type of patient we set out to study are in fact being discovered and coped with; the problem of the less obvious social needs of patients which we had not realised existed or intended to study would need much more research before the needs of such people could be met by any of the services at present involved.

* * * *

We would like to thank the Casualty Department for their co-operation and the Social Work Department for their help and support throughout our study.

APPENDIX I

CASUALTY SURVEY

We are doing a survey in order to find out the needs of patients coming to casualty. We would be grateful if you could help us by completing this form. Any information you give us will be treated as strictly confidential.

1. Please state your:—
   (a) Age
   (b) Sex
   (c) Marital Status
2. Do you live alone?
   If not please give brief details of the members of your household.
3. Do you have any contact with, or help from the Social Services in your area?
4. Have you been to this hospital before as an:—
   (a) in-patient ..... times
   (b) out-patient ..... times
   (c) casualty ..... times
   If so please give brief reasons.
5. Have you been to any other hospital?
   Name of Hospital(s)
   (a) in-patient ..... times
   (b) out-patient ..... times
   (c) casualty ..... times
   Please give reasons.

Thank you for your co-operation.

APPENDIX II

CASUALTY SURVEY

We are doing a survey in order to find out the needs of patients coming to casualty. We would be grateful if you could help us by completing this form. Any information you give us will be treated as strictly confidential.

1. Please state your:—
   (a) Name
   (b) Age
   (c) Sex
   (d) Marital Status
2. Do you live alone?
   If not, please give brief details of the members of your household including their age.
3. Do you have any contact with, or help from the Social Services in your area?
   (e.g. Welfare Department, Home Help, Children's Department Probation Service, Hospital Social Worker, School Welfare District Nurse, Health Visitor or Social Security etc.)
   If so which
4. Have you been to this hospital before as an:—
   (a) in-patient ..... times
   (b) out-patient ..... times
   (c) casualty ..... times
   If so please give brief reasons.
5. Have you been to any other hospital?
   Name of Hospital(s)
   (a) in-patient ..... times
   (b) out-patient ..... times
   (c) casualty ..... times
   Please give reasons.

Thank you for your co-operation.

APPENDIX III
CASUALTY SURVEY
FOLLOW UP

Part A. 1.
- (a) Name
- (b) Address
- (c) Occupation

2. How referred
   - (a) G.P.
   - (b) Casualty Appointment
   - (c) Casualty
3. Known to Casualty
   Why
4. Disposal.

Part B.
1. Risk Category
2. Known to Medical Social Work Department
3. Follow up if admitted.

APPENDIX V

We were interested in comparing the Social Work service given to Guy's Casualty with that of other large London hospitals. We therefore wrote to the Medical Social Work Departments of six hospitals, all of whom were very co-operative in supplying us with the information we requested and we are very grateful for their help.

We asked for a total number of patients attending Casualty over a specified period, the proportion of these who are referred to the Medical Social Work Department and for a brief description of how such referrals are dealt with.

The information we were given is as follows:—

Name of Hospital	No. of patients seen in Casualty	Period	No. Referred	How dealt with
Thomas'	18,323	Jan./Mar, 1971	112	Seen by full-time Welfare Assistant and M.S.W., who also has two other units. Most referrals taken by Welfare Assistant, more complex ones are discussed with Medical Social Worker either on consultative basis or with a view to her taking the case.
Fulham	54,508	Total, 1970	No separate Record	Each Social Worker has one casualty day.
	25,298	6/12/1970		
Royal Free	700	per week		One social worker with all
	Approx. 9,000	per 3 months	3–4	casualty referrals.
U.C.H.*	12,082	three months	15	Intake system.
Emergency Dept. 24-hr. Ward	963	three months	36	Duty day.

*U.C.H. have a new accident and emergency department. They have a 24-hour stay ward in which casualties not immediately discharged after treatment are either admitted to one of the wards or given treatment and then discharged.

It would appear that in the other hospitals which we consulted, a similar situation exists to that at Guy's and several social work departments expressed some uncertainty as to why they received so few referrals from Casualty. University College Hospital, where there is a different system with an emergency department and an accident and emergency ward to which patients can be admitted if necessary for 24 hours before discharged or transferred to another ward, appears to receive a larger number of referrals, particularly from the ward. The 24-hour ward probably allows more time to detect and deal with social problems. It is also interesting that University College Hospital Casualty staff have an increasing contact with community based social workers and that the staff are provided with an information manual for use out of office hours.

It is not possible to determine from this information whether or not our findings are applicable to other hospitals, but it may be that the general conclusions and comment we have made are relevant. We are very grateful for the trouble the social work departments have taken to supply us with such interesting information.

Horoscope

ARIES—Beware of tramps. You have an enemy who will probably feed your offal to the kites.

TAURUS—A lovely fortnight. You will receive a large sum of money—possibly a legacy. A new and exciting love affair is on the horizon.

GEMINI—Well, it's a new psyche plus £300 for you. Lucky Geminis! Unless you have a May birthday with Saturn on eclipse—in which case watch out for broken legs.

CANCER—Give up smoking—quick. I will say no more until you have *ALL* given it up.

LEO—Ever thought of keeping a pet? Don't. Oops! dropped another stitch. Try and be more positive. Strike up an acquaintance with a Capricorn—this is very important.

VIRGO—Stop bullying Pisces. Leave me alone. And watch out because I have a large Aries brother who will soon sort you out.

LIBRA—Just carry on smoking, eating and over-indulging. You will die soon. Make a will immediately, leaving everything to a tall, blond, friendly Taurean.

SCORPIO—Isn't it about time you grew up? Really. Have you never contemplated doing something useful for the community? All you ever think of is food and sex. I put it to you that you are a selfish parasite. I leave you with your thoughts.

SAGITTARIUS—Do be careful of the company you mix with this month. You are susceptible to diseases—avoid the sick room.

CAPRICORN—Now is the time to broaden your horizons. A word of warning—shun Leos as you would shun the plague.

AQUARIUS—We don't like you. Stop being nasty, horrid-looking bullies. Hope you have a dreadful fortnight.

PISCES—A lovely, lovely time. Better than anyone else's—and you deserve it. Mercury is liaising with Jupiter—can't be bad. Go on, enjoy yourself. T.B.F.T.

A Little Insight into the Hastings Horseman

I was lucky enough to meet the celebrated Hastings Horseman. It was towards the end of the exceedingly fine spell of weather we had at the end of July—the barometer had been stationary for nearly two weeks, I remember. I was driving back from the coast on that Sunday evening; I had not gone far—perhaps five miles, and the sun was setting; the air was full of insects and the occasional early moth, and the country lane I was travelling along was very pleasant. I remember climbing a steep hill—it required double de-clutching—and then descending an equally steep one, rounding a corner and finding a small collection of old cottages; on the right of the road, in the elbow of the bend, was a placid lake, and on the left three small tiled dwellings and a tavern. I slowed to inspect the inn and noticed beyond it a small garden with benches round a table. It seemed a pleasant place to sample and I stopped.

The beer was woody and good, and the peace superb; imagine yourself in those surroundings, savouring the flavour of it all: the only noise the steady rush of water falling over the dam at the head of the lake. Shortly I noticed a clip-clop, and over the top of the hill appeared a rider. He was dressed in an old grey-green raincoat and a worn-out brown trilby; the horse looked old and tired but well groomed, and the man sat hunched in the saddle, staring at the back of the nag's neck. As he rounded the corner I could see more of his features: his hands looked heavy and rough, the skin creased and dry; the face was round and also lined, and a grey stubble featured over his jaw; the nose was most striking—hooked and blue, and the eyes looked tired; matted strands of grey hair fell from under his trilby and hid his ear. He dismounted and tied his beast to a tree, and then came over to join me, introducing himself with the offer of a pint. He did not remove his raincoat or hat, but sank on to a bench opposite me and began with "They've been following me from the coast, and so I shan't stay long, just long enough to drink this and give the horse a rest."

"Please explain," I asked, and waited while he drained his glass.

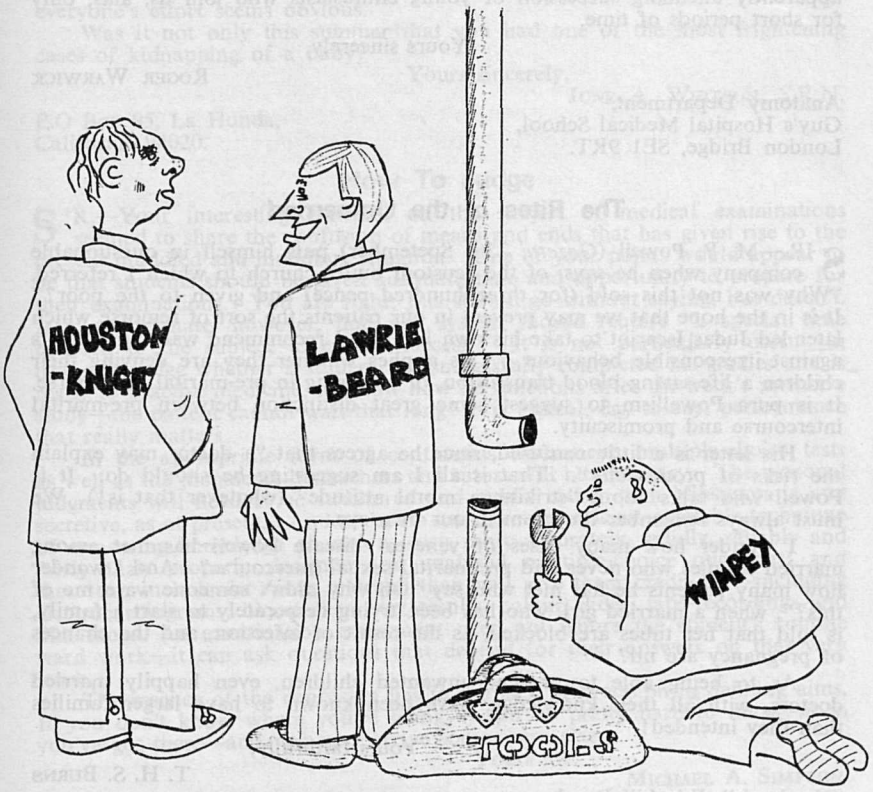
"The men from the knackers are after my horse; she doesn't really belong to me, but I sort of own her—always have, in fact; and now they reckon to turn her into dog meat. Devils, officious devils; give a man a white coat and he thinks he can do anything; he thinks he's got power; he wears a clean white coat with a little label on it saying 'Abattoir Assistant', and he's got identity at last," he continued. "Uniforms, numbers, white coats, labels—it's all the same; today a man needs a badge of office! A man in a clean white uniform, clean, huh! Show me a man in a white uniform that doesn't have dirt and bugs crawling down his trouser legs and off his socks; it's all vanity—an official uniform to hide behind and a badge for their record, and a label of identity. Give a man the chance to make his own identity and you have a man; put him in a standard sanitary garment and he must be a hidden man!

Without waiting for a reply he roughly cleared his throat, bade me farewell and goodnight, and slowly stood up; having wound himself up to the bent posture he adopted, he limped over to his horse, patted her on the neck, said something, mounted slowly and rode off.

It was by now almost dark, and he very soon disappeared. I said goodnight to the publican and asked him about the curious character I had just met: "Ah him, ah well. I think they call him the Hastings Horseman, like as because he's always to be found riding a tired horse around these parts in the evenings," he replied.

A strange coincidence that I should meet him then, and then hear of his death just five weeks later; still riding his horse. Strange man I thought; very peculiar indeed, but very interesting; or was he just paranoid? It was sad that the headlines, "Hastings Horseman Killed," in the evening paper, failed to precede an obituary; it would have been interesting to find out whether I was right. So my money was not entirely wasted, I had had some good memories of a pleasant evening.

J.O.



CORRESPONDENCE

The Anatomy Department

SIR,—It is a pity that your news item on recent activities in the Anatomy Department should have been blemished by one or two slips, which I beg to correct. I do so because, as I hope you will agree, credit should be given fairly where it is due. The photograph which you published was not by T. Blackburn, as stated, but by Kevin Fitzpatrick, who is the photographer in this department and also serves many people in the medical school. The whole development of videotapes as a means of helping students in dissecting was started by myself and certain junior lecturers in the department two or three years ago. My part in this was minimal, but it would be pleasant to put on record how much we owe to Peter Bowen-Simpkins and Peter Peace, both of whom have now gone elsewhere to further their careers in surgery. They handed on their experience to Julian Dussek and Michael Hutchinson, the latter of whom is still in the department. Julian Dussek was in particular a most valuable influence in regard to the technical side of our equipment. Already other junior lecturers who have joined the department have joined in with Dr. Hutchinson, and the whole of our achievement in this field is to me a most praiseworthy effort, and typical of the contribution made to this medical centre by younger people. I am sure that in other departments senior men feel equally delighted with the way their own efforts are backed up by an apparently unending succession of young enthusiasts who join us, alas, only for short periods of time.

Yours sincerely,

ROGER WARWICK

Anatomy Department,
Guy's Hospital Medical School,
London Bridge, SE1 9RT.

The Rites of the Unmarried

SIR,—M. P. Powell (*Gazette* 25th Spetember) puts himself in questionable company when he says, of the "custom built" church to which I referred, "Why was not this sold (for three hundred pence) and given to the poor?" It is in the hope that we may prevent in our patients the sort of remorse which later led Judas Iscariot to take his own life that I recommend warning patients against irresponsible behaviour. This applies whether they are denying their children a life-saving blood transfusion, or indulging in pre-marital intercourse. It is pure Powellism to suggest some great distinction between pre-marital intercourse and promiscuity.

His letter is a little confused, since he agrees that "a doctor may explain the risks of promiscuity". That is all I am suggesting he should do. It is Powell who talks about "striking a moral attitude" (whatever that is!) We must always remember the beam in our own eye.

I wonder how many cases of venereal disease Powell has met among married couples who never had pre-marital sexual intercourse? And I wonder how many patients he has met who say "Oh why didn't someone warn me of this?", when a married girl, who has been trying desperately to start a family, is told that her tubes are blocked, as the result of infection, and the chances of pregnancy are nil?

As to being able to prevent unwanted children, even happily married doctors, with all their knowledge, have been known to have larger families than they intended!

Yours faithfully,

T. H. S. BURNS

"Newlands", Edgehill Road,
London, W13 8HW.

Guy's in the Midlands

SIR,—It has been proposed that a dinner be held this winter for Guy's men and women living in the Midlands. Birmingham would seem the most apposite place to hold such a function, and it is hoped that a member of the Guy's Staff will attend as guest of honour.

Would all those Guy's men and women living in the Midlands, who would be interested in attending such a dinner, please communicate with me at the address below?

I am, etc.

B. H. BASS, M.D., F.R.C.P.

Department of Medicine,
Good Hope General Hospital,
Sutton Coldfield,
Warwickshire.

You Can Take It With You

SIR,—My copies of the *Gazette* arrive somewhat erratically, but even at this late date I would like to comment on "It's a Sizzler", Passim, 17th July.

Surely the need is not to educate the public to be aware of the dangers to babies of leaving them in cars, but to educate them to the joys of taking baby everywhere with them, dressed of course appropriately for hot or cold weather.

In these days when every conceivable type of carrycot, push-chair, front and back carriers are available to parents, at no great cost, the direction of everyone's effort seems obvious.

Was it not only this summer that you had one of the most frightening cases of kidnapping of a baby?

Yours sincerely,

JUNE A. WHITSON, S.R.N.

P.O Box 95, La Honda,
California 94020.

How To Judge

SIR,—Your interesting editorial on the subject of medical examinations seemed to share the confusion of means and ends that has given rise to the present muddled and muddling situation. One of your points would appear to be that students should be given adequate time and opportunity to prepare for their examinations. You are right; this should go without saying, but doesn't. It is unfortunate, however, that our system should require "a special time devoted to the subject to ensure success". It is not particularly useful, in trying to judge whether a student has successfully completed his studies and is ready to practise medicine, to know how he functions after six week's intensive study—the patient cannot wait that long! It is typical, day-to-day, performance that really matters.

In the appropriate form of continuous assessment, multiple-choice tests as well as the judgments of teachers and tutors will be necessary. The personal judgments will need to be structured and public rather than idiosyncratic and secretive, as at present. And make no mistake—there is no available technique of measuring knowledge of various sorts more accurately, validly, reliably and fairly than properly designed and analysed multiple-choice questions; and these can include far more material than you give them credit for—including electrocardiograms, blood chemistry results, colour slides, tape-recordings and film loops. An examination assessment need not ignore the student's routine ward work—it can ask questions that depend for their answers on that very work.

The essence of the confusion lies in the lack of precision in defining aims. If you don't know where you're going, it can be pretty hard to know when you've got there—and you may arrive somewhere else.

Yours etc.

MICHAEL A. SIMPSON.

Guy's Hospital,
London.

NURSING SECTION

CAREERS ADVICE

One of the most notable facilities of which nurses are deprived is that of a system of careers advice.

This lack is felt at all levels of the Profession, and appears to be a service which has never been provided and which currently is not thought necessary by any organisation.

If such a system is considered necessary in other Professions, why not so in nursing? Unfortunately, there still seems to be a popular impression that the eighteen-year-old who elects to undertake such a career will traverse a pre-determined course without any thought as to her future. This, of course, is a grossly inaccurate assessment, and also a reason why many nurses are lost to other occupations.

Nurses, by the nature of their training, tend to become inflexible and subjective in their views. Thus the trainee does not consider her career as a whole, but merely thinks of the period leading to qualification, and little beyond that. Likewise, her senior colleagues are so concerned with staff shortages that they cannot view the fact that students may wish to progress beyond State Registration with equanimity. When nurses state that they propose to undertake further training, these people are disturbed by the problem of yet more posts to fill and are not prepared to accept the fact that the Profession as a whole will benefit.

Not only students, of course, experience problems regarding their career. The older person often would much appreciate the assistance of some advice. Unfortunately it is true that the very small amount which is available decreases in proportion to seniority and is directed mainly at pre-registration nurses. Whereas one would concede that it is at this level the need is greatest, it does not cease immediately after the acquisition of one qualification.

Surely there is a place for a Careers Advice Service within the Profession. The number of staff employed in one hospital or group thereof would certainly provide sufficient occupation for an officer appointed for this purpose. Moreover, many people would prefer to obtain advice in a setting divorced from either a nursing school, or administrative office.

If such a scheme were to become universally established many deserters from the profession might possibly be salvaged. Disillusionment is the reason for large numbers making the decision to enter other fields of work. Having gained a qualification there appears to be little chance of further betterment. After fruitless attempts to discover just what posts are open, the struggle becomes too great and thus it is simpler to abandon the idea.

If careers advice were, however, available, and less nurses did leave the profession, this would automatically increase the standards provided for the patients. This would inevitably raise the morale within the ranks, which could only prove beneficial to all concerned.

SPORT

RUGBY 1st XV

SATURDAY, 9th OCTOBER

Cambridge 1st XV: 7 Guy's 1st XV: 7.

The Guy's 1st XV travelled to Cambridge on Saturday intent on avenging the unfortunate 66-0 defeat conceded last year.

Cambridge fielded a strong team which contained blues and numerous county players. Guy's won the toss and elected to play with the wind and sun behind them. Guy's got off to a shaky start and the Cambridge pack and backs looked very dangerous. In the twentieth minute the Hospital conceded a penalty which was successfully kicked. The Guy's team were now playing much better and the pack won good ball from both loose and set pieces. Unsuccessful penalty attempts were made by Novak and Danford, both, missing very narrowly.

The second half saw Guy's playing against the wind but, inspired by the excellent play of captain Carter Croft, they played brilliantly. The line-outs and scrums were won easily and in the loose, Allen, Novak, Fallowfield, Burt, Evans, Stewart and Rosewall were excellent. The three-quarters handled safely and the tackling was sure. Druett, Campbell, Armstrong and Jones played well and our full-back Danford was safe and kicked well. The linesman was prominent.

However, after a loose maul and a doubtful handling move, Cambridge scored a try, which they failed to convert. Twenty-five minutes into the second half, after a loose maul, Novak picked up the ball and ran all of 80 yards through the Cambridge side to score a magnificent try. This was not converted. The Guy's team continued to pile on the pressure and looked the better and fitter side. Ten minutes from time, Novak successfully kicked a penalty from well outside the twenty-five line, making the score 7-7. From then until the final whistle Guy's looked, all the time, like scoring (Cries of "Come on 'Varsity only 60 points to go" had long died out). Unfortunately, at the final whistle the score was seven points each, but the Guy's team had clearly shown their superiority.

B.K.M.

GUY'S 2nd XV v. SUTTON SWALLOWS

The 2nd XV have got off to a most promising start to the season by defeating two powerful sides, U.S. Portsmouth (20—13) and Sutton Swallows (28—4).

Against Sutton, Guy's introduced three freshers to the team. "Taffy" Owen at outside-half, Mick Gilhooly at wing-forward and, from Cambridge, Phil Reesbeck, also at wing-forward. All three played very well, which promises well for the future, as there are several other freshers who will soon be knocking at the door of the team.

Guy's, as usual, started slowly, being pinned in their own twenty-five for the first ten minutes. After this the powerful Guy's eight gradually started wearing down the opposition, getting plenty of good ball for the backs, who showed much promise and with a little more practice should produce an excellent combination. Paul Board, in the centre, deserves special mention, making several penetrating runs and scoring two fine tries. "Taffy" Owen didn't drop a ball all afternoon and made several daring runs and kicked accurately. Making a welcome return to the rugby scene was John Shutes, who is back to his best form, tackling magnificently and making some determined runs. Unfortunately, several scoring passes were dropped and coupled with the fact that Guy's attempted to run several penalties when they were in easy kicking distance, the score would have been in the fifties. Ken Rigg played a storming game at No. 8, making several assaults on the line; unfortunately, although he thought he scored three tries, the referee only allowed one, which didn't please Ken. Roger Massey, despite playing most of the game concussed, scored a memorable try after all eight forwards had handled the ball. Chris Howell surprised everyone, including himself, by scoring a

great individual try, breaking from a loose scrum, selling a dummy and sprinting at least twenty-five yards for a try. Steve Challacombe, leading the pack, had his typical hard grafting game, winning much good ball at the front of the line-out.

So it is hoped the 2nd XV will continue to play with as much enthusiasm as in the first two games. It is hoped that there will be much competition for places from the Freshers, and as many people will attend training on Mondays and Wednesday, at 5.30, as possible.

People who have represented the 2nd XV in the first two games :—J. Rees, D. Dent, D. Norfolk, T. Mellor, P. Board, J. Shutes, R. Pascoe, T. Owen, D. Oram, D. Merrett, G. Marcus, C. Howell, J. Forbes, M. Portelly, R. Burlinson, S. Challacombe, K. Rigg, J. Ross, B. McLeod, P. Reesbeck, and A. *Gilhooly*.

D.J.M.

UNITED HOSPITALS' 7-A-SIDE TOURNAMENT

Final Result: Guy's 20, St. Bart's 6.

The annual U.H. Sevens Tournament was held earlier in the season than usual in an attempt to attract more teams and spectators. In this respect, and in others, it succeeded, and though the games lacked the speed and organisation of previous years, for obvious reasons, it proved a great success, and especially so for Guy's.

Guy's fielded without doubt the smallest seven of the day, with four players under 5ft. 8in. (a record?). What they lacked in size they made up with an exhibition of rugby skill and stamina which fully justified the hard work of the season's training sessions at H.O.P.

The first two rounds proved a worrying time for the small but vociferous band of Guy's supporters, as on both occasions Guy's crossed over 0—10 and 0—8 down against U.C.H. and London I respectively. The second halves, however saw Guy's play more constructive rugby and run out eventual winners at 24—10 and 18—8.

The final against Bart's was, without doubt, the best game of the day. Bart's fielded a huge side of running forwards and concentrated on their own familiar game of close backing up and supportive play with such success that Guy's touched the ball but twice in the first half. Spirited tackling meant that the score was only 0—6 at the changeover.

Guy's with the advantage of the wind and slight slope, began the second half with far more purpose. The ball was now slippery, following a sudden rainstorm, and the Guy's forwards of Novak, Fallowfield and Board found this to their liking. A break on half-way by Novak saw the ball handled by six of the Guy's side before Armstrong sprinted clear to score under the posts. Novak converted.

Bart's countered this with a well taken try but first Fallowfield and then Merrett, who played a fine controlled game, pounced on loose balls to dribble clear of the defence to score twice.

Novak converted from well out on the touchline and the game was won.

Team: B. Armstrong, C. Croft (Captain), D. Barrough, D. Merrett, T. Fallowfield, P. Board, J. Novak.

The Guy's 2nd VII had a difficult task in their first game against Westminster I. and worked hard only to lose 10—8 in the dying seconds. Stuart and Druett were the try scorers, the latter running 80 yards with a Westminster player a few feet behind, to collapse in an exhausted heap. Training has already begun for the side's next appearance in the Middlesex Sevens.

Team: R. Massey, J. Shutes, T. Druett, J. Rees, T. Want, D. Stuart, and T. Gibson.

GUY'S ANGELS v. SUTTON IV

Won 58-13

The Angels travelled to Sutton still smarting from their defeat the previous week at the hands of Metropolitan Police 3rds and anxious to show the world what Angels' Rugby is really like. They surprised everyone with their fine performance.

Sutton had no answer to the Angels' fierce scrummaging and determined running and soon found themselves behind, two early tries from Rex Yetton and Rod Robinson, were followed by a steady stream of tries from this talented Angels side.

The Sutton full-back landed three penalties in this first half, the Angels pack being repeatedly penalised for over-enthusiastically chasing the ball (back into the scrum from their opponent's side). Howard Fleet particularly impressed by his dogged enthusiasm!

After half time, the demoralised Sutton side (losing 9-30) showed added fire and determination but the Angels were playing magnificently and try followed try. Thanks go to veteran Colin Ryan who somehow managed to be near enough to the line to fall over with the ball ON TWO SEPARATE OCCASIONS!!

The game was almost at an end when a mix-up occurred between Angels players in mid-field as to who was going to score next, with the result that Sutton won a five yard scrum from which they scored a good try in the corner.

All in all, the afternoon and evening provided that stimulus which the Angels needed. Let us hope that the unique Angels' spirit will continue throughout the season—a season of victories.

Team: D. Glenn, R. Robinson, T. Thornton, G. Dunbar, R. Yetton, D. Gatland, N. King, P. Watkin, D. Young, C. Ryan, K. Faulkner, W. Hutton, A. Royston, J. Clark, H. Fleet.

Scorers: Tries—Robinson (4), Yetton (3), Thornton (2), Ryan (2), Hutton (1); Conversions— Gatland (3), Yetton (1), Thornton (1).

HOCKEY

GUY'S v. IMPERIAL COLLEGE

Result: Lost 1—5.

This was only the second game of the season for Guy's and four of the strongest players were missing, including the captain, Paul Calvert, who has retired to bed with infectious hepatitis. However, I.C. well deserved their win though perhaps not by as many goals.

Although the rain was coming down hard all morning, the ground was deemed fit for play, and a game closely resembling ice hockey was performed on the sacrificial pitch.

The ritual cries of "off-side" and "feet" echoed from the Guy's defence as three goals followed each other in close succession after half-time. The Guy's goal scored by R. Burns had to be helped on its way into the net by a defender, and so the side, a little dejected, had to swallow its pride until it gets its revenge in the Collegiate Cup.

Our thanks must go to the two umpires, who were both "blowing" for the first time, and managed to control a game that could easily have got out of hand.

R.W.B.

BOAT CLUB

THE LINCOLN TO BOSTON MARATHON, 1971

1st IV winners of the Captain's Cup, placed fifth overall in 3 hrs. 45 mins.
1st VIII placed eighteenth in 4 hrs. 09 mins.
Mixed IV placed ninety-eighth in 6 hrs. 05 mins.

The 1st IV:

BOSTON MARATHON WIN

This year the Coxless IV covered this gruelling 31-mile course to easily win their class, in 3 hours, 45 minutes.

Early after the start the crew was, unfortunately, steered into the bank, breaking a blade and knocking most of their drink into the bottom of the boat. (Professor McDonald's "magic" Calsall once again!)

Undeterred, they ploughed on through the opposition, crossing the portage (at 7 miles) in a very fast 50 minutes.

This 8 m.p.h. average was maintained throughout the painful hours of unending bends and straights ahead.

In order to keep the pressure on, the "veteran" bow pair, Mike Gleeson and James Miller carried watches and a time schedule for various landmarks. The lesser experienced (in this type of rowing) stern pair of Paul Stewart-Bennett and Andy Chivers, were kept guessing.

The strategy worked very well, the nearest opposition finishing 15 minutes behind.

Crew: Stroke, A. Chivers; 2, J. Miller; 3, P. Stuart-Bennett; Bow, M. J. Gleeson (Cox).

J.C.M.

The 1st VIII:

The eight had a thoroughly enjoyable weekend. We arrived in Lincoln after an eventful journey, on Saturday afternoon keen, fit and in time for cream tea in the shadow of the cathedral. Later we visited this magnificent building which met with our full approval. That evening we dined sumptuously at Downie's—strongly recommended for next year's crew, although the service was not quite up to the Spit standard. We retired to bed at 10.30 p.m.

Came the dawn, the men refreshed by the night's repose, broke their fast consuming vast quantities of fruit juice, cornflakes, bacon and eggs and all the captain's toast and marmalade.

The race itself was rowed without mishap and to the enjoyment of all except the bow, three, and cox, who argued persistently. Even so, the crew finished in the remarkable time of 4 hrs. 09 mins., a good ten minutes faster than last year.

Crew: Bow, P. Reed; 2, M. Howes; 3, G. Bergman; 4, D. Barker; 5, C. Price; 6, G. Moulding; 7, R. Pinkney, Stroke, R. Newton; Cox, F. Moorhouse.

The Mixed IV:

For the first time in its history, Guy's entered a mixed, coxed IV for this 32-mile marathon.

As it had not been possible for the crew members, to train or row together prior to the event, and with neither of the female members having previously rowed a course longer than four miles, it promised to be a completely novel experience for all concerned.

Several last-minute repair jobs prevented the crew from leaving Lincoln before 11 a.m., but it was agreed that the best plan would be to maintain a steady rating of 26 throughout the course. However, proceedings were held up within a mile from the start when No. 2 noticed water entering through a crack in the hull, causing stroke's invaluable "Dextrasol" tablets to go into liquidation.

Thus on reaching Bardney Lock six miles later, Guy's supporters aided the male crew members in removing the water—whilst the females in the crew took the opportunity of removing as much clothing as cox and decency would allow, this producing many ribald comments from fishermen and passing crews.

Having ensured that they were well (Elasto) plastered before the race, the crew found it was only necessary to stop for salt, glucose and liquid refreshment every 1¼ hours—accurate timechecks being provided throughout the race by courtesy of Radio One.

Tattershall Bridge was reached by 3.45 p.m., by which time blisters, boredom and unnatural suntans were becoming painfully obvious—and the subsequent distance of 11 miles to Boston was unanimously regarded as the most gruelling part of the course.

It was therefore a great relief when cox spotted the finishing line one mile in the distance—and the crew then felt sufficiently cheered to increase the rating to get home in advance of "Pick of the Pops" and a pursuing rival female crew.

In spite of taking 1,400 strokes per hour for well over five hours, the crew finished the course feeling reasonably fit, and attribute much of their success to encouragement and advice provided by Guy's supporters and oarsmen both before and during the race.

Crew: Bow, Mary Wade; 2, Keith Freeman; 3, Michael Lilley; Stroke, Elizabeth Ryman; Cox, David Evans.

SWIMMING GALA

The London Inter-Hospital Physiotherapy Schools' Swimming Gala was held at the University of London Baths on Tuesday, 5th October. The winners were the London Hospital, with the Middlesex second, and Guy's third.

Guy's were represented by:—Caroline Jackson (Capt.), Jackie Barton, Naomi Robins, Heather Strange, Leigh Stock, Elizabeth Pote, Deborah McCabe, Linda Magill, and Lynn Hall (reserve).

OBITUARY

WILLIAM EDWIN BERWICK, M.B.E.

"Teddy" Berwick, who died on 5th October after a short illness in Putney Hospital, qualified from Guy's early in 1924, and was one of the quieter members of our profession who achieved much in its progress. Starting practice in Putney, he did part-time work as a school dental surgeon to the Wandsworth and Paddington Districts, where his gentle manner with the *then* "difficult parent" had always a successful culmination and the same attribute soon built him a very successful practice.

Before the 1914/18 War he was in the London Scottish and on the outbreak of war was transferred to the Argyll and Sutherland Highlanders, there obtaining the rank of Captain, and eventually was transferred to the Royal Flying Corps, where, for his outstanding services, he was awarded the M.B.E.

Quite early in his career he was appointed Dental Surgeon to the Richmond and Putney Hospitals and there succeeded in establishing an efficient Dental Department which previously had more or less been non-existent.

From his student days his hobbies were concentrated on River Thames activities, from leisurely punting to cabin cruiser comfort, and much of his early study was (in the summer vacation) undertaken in a hammock slung between two trees at his mooring.

His massive effort in establishing an ethical and high-class practice is rewarded by the fact that his two sons, William and Colin, are both Dental Surgeons, William being Consultant at the Brompton Hospital and Colin (Retired Lt.-Cmdr. (D) R.N.R.) are carrying on the practice together with a loyal staff of many years' standing whom "Teddy" with his gentle charm, has succeeded in keeping with him.

Our deepest sympathy goes out to his wife, Miriam, and his two sons.

F.B.

HOSPITAL INFORMATION

PERSONAL

COMFORTABLE furnished flat available in Buckinghamshire village for Guy's doctor who wishes to do part-time work. Please apply to Dr. David Ellis, 36, Amersham Road, High Wycombe. Tel: High Wycombe 22755.

CHANGES OF ADDRESS

Adrian John Gillham, Dental Centre, Ministry of Health, Benue Plateau Stak, Jos, Nigeria. (Recently accepted Voluntary Service Overseas appointment.)

J. J. Hall, Esq., B.D.S., Flamston House, Bishopstone, Salisbury, Wilts.

Professor and Mrs. Robert Kark wish to announce their change of address to: Apartment 5W, 220, East Walton Place, Chicago, Illinois, 60611, U.S.A. Tel: (Area code 312) 943-2034.

Dr. D. J. Morton, 3, Marmion Crescent, North Berwick, East Lothian, Scotland. Tel: 0620 2330.

Dr. and Mrs. Chris Newman, 48, Heather Road, Lee, London, S.E.12. Tel: 01-857 6395.

Dr. M. D. O'Brien, Department of Neurology, University of Minnesota School of Medicine, Minneapolis, Minnesota, U.S.A. from 12th December, 1971.

Mr. and Mrs. K. M. Pagliero, 1, Pond Close, Harefield, Middlesex.

Dr. and Mrs. A. M. Roberts, 11, Wastwater Rise, Seascale, Cumberland. Tel: Seascale 459.

Mr. and Mrs. F. S. Warner, "Nobles", Earlswood, Fairmile Lane, Cobham, Surrey.

BIRTHS

PAGLIERO—To Anne (née Saunders) and Michael Pagliero on 22nd August a daughter, Helen Rose, a sister for David.

PETERSON—On 24th September to Lesley (née Mansie) and Michael Peterson, a son (Angus John Narramore).

MARRIAGES

ROBERTS—ERSKINE—On 18th September, 1971 at St. John's Church, Stanmore, Dr. Murray Roberts to Miss Lesley Erskine.

ROBINSON—JENKINS—On 7th August, 1971, at Orpington Methodist Church, Roderick James Robinson of Solihull to Ruth Margaret Jenkins of Orpington.

ENGAGEMENT

Sister Sally Coxon, of Addison Ward, and Dr. John Rawlinson of Addenbrooke's Hospital, Cambridge announce their engagement.

Miss Yasmeen Ihsan Khan, of Fatima Jinnah Medical College, Lahore, and Dr. Malik Mubbashar of the York Clinic, announce their engagement.

DEATHS

VISSER—In Durban, Natal in 1970, Jan Dirk Jacobus Visser, qualified L.D.S., R.C.S., Guy's 1925 and late of 34, Field Street, Durban.

We would like to remind our readers that all copy for inclusion in the "Gazette" must be received eight days before publication date.

Copy may be sent to us c/o The Front Lodge, Guy's Hospital.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, please indicate whether or not this should be published.

Personal notices 5p per word (pre-paid) (minimum £1.05).

Non-subscribers will pay £1.05 (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

EDITORS A. M. TURNER and J. L. LEWIS
NEWS EDITORS C. G. CHINERY and D. I. F. KELLEHER
SPORTS CORRESPONDENT A. M. ROYSTON
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TEN PENCE VOLUME 85 NUMBER 2174

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Keeping our own wounds green

Revenge, or turning the other face, has been more obviously than most things both officially condemned and officially sanctioned for at least the last two thousand years or so since God became a gentleman. Aged Nazis await death in Allied gaols, no doubt thanking the gentleman to whom previously referred for the mercy of the Allies, while Emperor Hirohito of Japan is given an official welcome to countries of the West, in a most tasteless display of poor manners to the victims and their families of the Japanese war prisons. Those of us who did not suffer would do well to resist showing heartfelt delight in entertaining the leader of such atrocious torturers and wait a generation until the sufferers or their persecutors are no longer here to offend one another.

At the same time, however, we should do nothing to encourage further the jingoism that persists in this country more than thirty years after the end of the last world war. To the extent of erecting statues to him and naming collections of bricks after him, we still revere the man who was British leader during the Second World War. He certainly deserved our thanks during his lifetime, but continued posthumous reverence for a man and his system which led Britons to kill is surely misplaced. We should cease dwelling on the glory of that war. The point is important; we have progressed no further since then. Violent solutions are sought for political problems in Ireland, and to social problems in British cities where violent crime is increasing. Honest citizens deplore the violence while erecting monuments to their own victorious violence and are then perplexed that setting up an inadequate national health service, an inadequate free education service and unemployment benefit has not brought an end to the aggression that stems from frustration of the under-privileged. Those social benefits must help eventually but so little equality exists as yet that resentment still breeds and with our tribal reverence for violent solutions it is hardly surprising that glory is sought in an urban fight for liberty. The desire so strong for liberty in the deprived has

changed into a desire for cruelty and revenge on those who benefit at present, in the same way as those in power at the moment exercise their revenge on those that have opposed them in the past.

It is often maintained that the force imposed by the just British is not vengeance but sage, cool deterrence. That practical use of force as a means to a good end is said to permeate our political and legal attitudes. But in what sense can it be said that anybody has been deterred from war because of the Second World War trials and consequent sentences? Or on a more domestic basis, can the idea seriously be entertained that a young woman who snatched a baby so that she could have someone of her own for whom to care is in need of three years in prison to help her from doing it again? Would such a sentence change the minds of other emotionally deprived, pathetic girls who were impelled to run away with babies? It seems unlikely. The only explanation behind our severe behaviour to people who offend us is we simply wish to venge ourselves cruelly.

The Examination Game

It is common knowledge that examinations are stressful times. Any observant person can detect an alarming rise in the pulse rate of a candidate waiting to be called into an oral examination. Even the most passive exterior can conceal a massive tachycardia. There are other parameters of panic which can be observed or measured. For example, changes in appetite can occur and many people may notice a pre-examination diuresis. One the whole, examination candidates are prime examples of the fright-flight-fight response. Some give up at the first stage, while others progress to the third and decide to face their examiners.

It cannot be said that examinations are intrinsically terrifying or that they should be. They are meant to be a test of one's proficiency in a subject. However, examination candidates will never be convinced of this and as a result display odd behaviour.

The medical student is most peculiar. As the Great Trauma approaches, he emerges with a modified short-back-and-sides and clothed in a three-piece suit and an old school tie. His change in appearance is so striking that he is laughed at by his friends, and classified as a curiosity by bewildered patients. As soon as the examination is over, the medical student reverts to his usual mode of dress. At no point is the action questioined and some students observe this ritual with alarming sincerity.

The fact that many students believe it necessary to alter their appearance reveals their confusion about the purpose of finals. They justify their last-minute trims by saying that trivialities such as dress or hair length can tip the balance when marks are borderline. This implies that they believe that the examination is useless at determining who is "safe" to practise and that in the final analysis appearance is more important than knowledge. Finals, therefore, represent an entrance examination to a select social subgroup which frowns on non-conformists.

As the purpose of the final medical examination is to sort out the candidates who will be "safe" housemen, there should be no need for students to change their appearance for its duration. Haircuts, like tachycardias are, in most cases, temporary and meaningless gestures.

GUY'S DIARY

NOVEMBER

8	M	1.00 Clinical Lecture. Professor McCOLL.
		5.30 The Scentific Basis of Medicine.* Professor LYNNE REID: "Properties of Mucus."
9	Tu	5.00 Clinical Medicine.* Dr. WATKINS. "Diabetic Ketoacidosis."
		6.00 Update.* Dr. OAKLEY. "Bedside Diagnosis of Heart Disease. Part I."
12	F	2.15 Combined Round. Dr. HYAMS. "Several Cases of Ataxia."
15	M	5.30 The Scientific Basis of Medicine.* Professor PERKINS: "Ocular Toxoplasmosis."
16	Tu	1.00 Clinical Lecture. Mr. KILPATRICK.
		5.00 Clinical Medicine.* Dr. GILSTON. "Mechanical Ventilation."
		6.00 Update.* Dr. OAKLEY. "Bedside Diagnosis of Heart Disease. Part II."
19	F	1.00 Clinical Lecture. Dr. SCOTT.
		2.15 Combined Round. Dr. ANDERSON and others. "Population Control."

*Denotes that the programmes are televised and shown in the Anatomy Lecture Theatre.

The Combined Rounds will be held in the Pre-Clinical Classroom.

NEWS IN BRIEF

Bomb Scare at Guy's

The daily routine of Guy's was disrupted last Monday morning by a police search. This followed an anonymous telephone call to the local police, at about 8.30 a.m., saying there was "a bomb planted in the New Wing".

The police, who were also dealing with two other bomb scares in the area, immediately sent all available officers to the hospital, and commenced a search. The nursing staff co-operated by moving all patients in New Guy's House to the end of the ward furthest from the New Wing. Entry to New Guy's House was restricted, and Guy's received no casualties from the ambulance service.

At about 12.15 p.m. the police search was completed, and with nothing found, Guy's slowly returned to normal.

Thus, for a whole morning, much of the workings of the hospital were disrupted, the casualty section more or less closed, and patients were both distressed and inconvenienced.

Sir Hedley Atkins

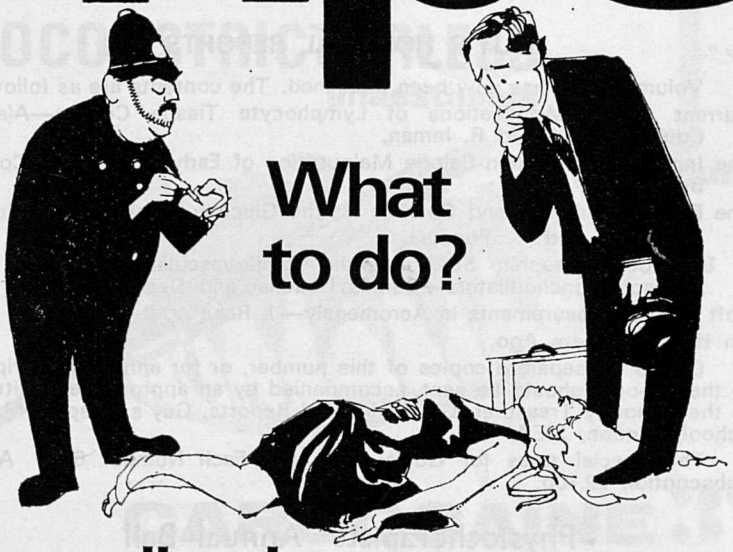
The Guy's Hospital *Gazette* of 5th October, 1929, recorded the arrival of Atkins, H. J. B., and this issue records his retirement from the Department of Surgery after 42 years' service to the hospital. He was educated at Rugby School and Trinity College, Oxford, and qualified B.M., B.Ch. in 1932. He was appointed Assistant Surgeon to Guy's Hospital and Hunterian Professor of the Royal College of Surgeons in 1936, having achieved F.R.C.S. in 1932 and M.Ch. in 1936. He served in the Royal Army Medical Corps between 1939-44 and retired with the rank of Lieutenant-Colonel. In 1947 he became Director of the Department of Surgery and in 1948 Surgeon to the hospital. Subsequently he was a member of the General Medical Council and the Council of the Royal College of Surgeons and was elected President of the Royal College of Surgeons in 1966. He became a Knight of the British Empire in 1967.

In addition to these honours he has been an examiner to the Universities of Cambridge, London, Durham and the West Indies, and Chairman of many Medical Research Council committees on subjects ranging from Tristan da Cunha to gastric hypothermia. He recently received an honorary Doctorate from the University of Kent and is an honorary Fellow of the American and Australasian Colleges of Surgeons.

We wish him an equally rewarding and energetic retirement at Downe House, where many students have appreciated his and Lady Atkins' hospitality.

(Photo copyright F. J. Pitts)

mps



medical protection society est 1892

Unlimited legal aid
and indemnity against
professional hazards
throughout the world
(except U.S.A.)

Secretary Dr. H. A. Constable. Head Office
50 Hallam Street, London, W1N 6DE. Tel: 01-580 9241
or Regional Secretary Dr. P. G. T. Ford
Regional Office: 30 Park Square, Leeds 1. Tel: 0532 42115-6

Professor C. A. Clarke

Professor C. A. Clarke, C.B.E., M.D., F.R.C.P., F.R.C.O.G., F.R.S., has been appointed Senior Censor and First Vice-President of the Royal College of Physicians of London.

D. A. Reynolds

D. A. Reynolds, F.R.C.S., who was in Guy's from 1954 to 1960, has recently been appointed Consultant Orthopaedic Surgeon to St. Thomas's Hospital, S.E.1.

NOTICES

GUY'S HOSPITAL REPORTS

Volume 120/2 has now been published. The contents are as follows:—

Current Clinical Applications of Lymphocyte Tissue Culture—Alan S. Coulson and David R. Inman.

The Incidence of Protein-Calorie Malnutrition of Early Childhood—Colin B. Brown.

The Effect of Adenine and Guanine on the Glucose uptake of the Heart—A. Kaldor and G. Pogatsa.

A Ballistocardiographic Study of the Cardiovascular Effects of some Aerosol Bronchodilators—Dennis Deuchar and Denise Higgins.

Soft Tissue Measurements in Acromegaly—J. Rake et al.

On Hundred Years Ago.

Orders for separate copies of this number, or for annual subscriptions to the Reports, should be sent, accompanied by an appropriate remittance, to the Honorary Treasurer, Guy's Hospital Reports, Guy's Hospital Medical School, London, S.E.1.

The special rates for Guy's men are: Each Number 63p. Annual Subscription £2.10p.

Physiotherapists' Annual Ball

The Physiotherapy Students of Guy's Hospital are pleased to announce that two hundred and thirty pounds were raised at their Annual Ball in September for the Hume-Kendall Trust Fund, and the Imperial Cancer Research Fund.

Guy's Hospital Nurses' League

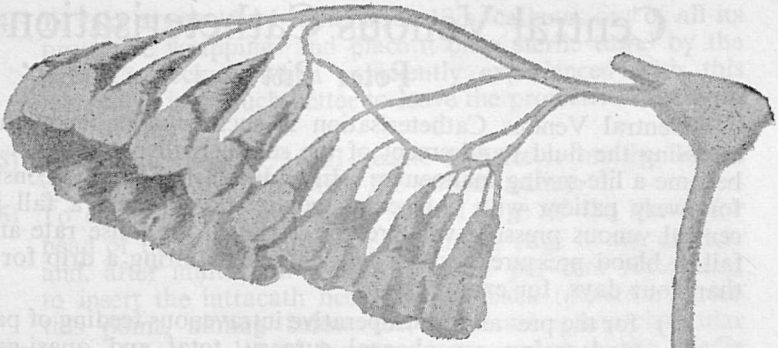
The Sir Cosmo and Lady Mabel Bonsor Scholarship, 1972

The Scholarship, value £250, is awarded to members for post-registration study at home or abroad.

Applications to The Matron, Guy's Hospital, before 11th January, 1972, with details of the course to be undertaken.

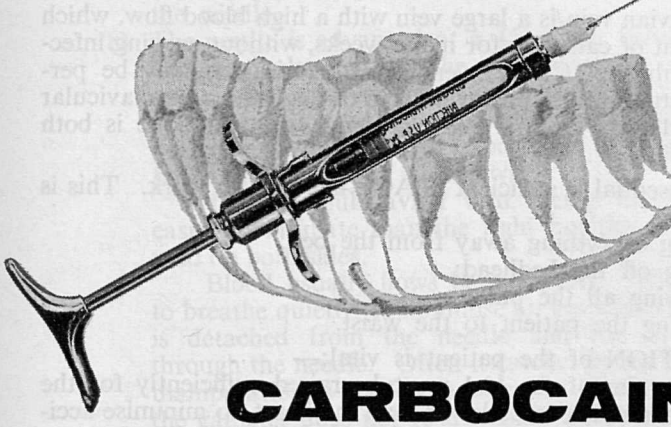
Guy's Hospital Ladies' Association Cookery Book

The Guy's Hospital Ladies' Association Cookery Book has just been published, price 50p. Copies available. Apply to Mrs. Salmon, Ladies' Association.



VASOCONSTRICTORLESS

anaesthesia for routine procedures



CARBOCAINE 3%

provides

- Rapid onset of profound operative anaesthesia
- Minimal tissue disturbance on injection
- Duration of anaesthesia sufficient for most routine procedures without unnecessarily prolonged soft-tissue anaesthesia
- Safety as regards toxicity and tolerance in all age groups

PRESENTATION

Boxes of 50 x 1.8 ml. cartridges. Each 1 ml. of CARBOCAINE 3% contains 30 mg. Mepivacaine HCl.

DOSAGE

Infiltration: 1–1½ ml. will induce anaesthesia lasting 15–30 minutes in the upper jaw and 30–40 minutes in the lower jaw.
Nerve block: 1.8 ml. provides anaesthesia for a minimum of 1 hour.
Maximum dose: 13 ml. (390 mg.) i.e. 7 cartridges.

CONTRAINDICATIONS & SIDE EFFECTS

None known at the present time. Any adverse reaction would probably be due to accidental intravascular injection and may include nausea, vomiting, hypotension, convulsions and respiratory depression. Such reactions are usually readily controlled with oxygen and pressor drugs. In all cases injection should be performed slowly.

Full information from

Made in England by
PHARMACEUTICAL MANUFACTURING COMPANY
Westhoughton, Epsom and Dublin
Member of the Willows Francis Group

CARBOCAINE is made in England under licence from AB Bofors, Sweden.

Central Venous Catheterisation

Peter Pitt

Central Venous Catheterisation is such a valuable method of assessing the fluid requirement of the seriously-ill patient that it has become a life-saving manoeuvre. In addition it should be considered for every patient with a bleeding peptic ulcer, where a fall in the central venous pressure will precede a rise in the pulse rate and the fall in blood pressure, and for any patient requiring a drip for more than four days, for example:—

(1) for the pre- and post-operative intravenous feeding of patients undergoing oesophageal surgery, total and quasi-gastrectomies;
(2) patients with Gram negative septicaemia—a much commoner condition than is often suspected;
(3) management of patients with intestinal fistulae.

The subclavian vein is a large vein with a high blood flow, which makes it tolerant of catheters for many weeks, without ensuing infection and thrombosis. Central venous catheterisation may be performed by puncture of the subclavian vein through the supraclavicular approach (Hardaway 1968). Once mastered, the technique is both simple and rapid.

The first essential is sufficient SPACE in which to work. This is obtained by:—

(1) Moving everything away from the bed;
(2) Taking off the bedhead;
(3) Removing all the pillows;
(4) Stripping the patient to the waist.

The POSITION of the patient is vital:—

(1) The bottom of the bed must be raised sufficiently for the subclavian vein to be lower than the heart, to minimise accidental air embolism. It may be necessary to put fracture boards under the mattress in a sagging bed to ensure the head is really lower than the heart.
(2) the patient is asked to turn his head away from the side of the injection, where it is held by a nurse with pressure on the chin. This helps demonstrate the clavicular head of the sternomastoid.
(3) The ipsilateral arm is forced straight down by the side.

The TECHNIQUE is:—

(1) To have the drip and central venous pressure manometer fitted up and filled with normal saline before intubation. Some of the saline is dripped into the one disposable galley pot of each disposable pack.
(2) To ensure decent illumination.
(3) Using sterile gloves to fill a 10 ml. syringe with the saline, fill the now empty galley pot with a skin preparation, clean the skin and place several sterile paper towels under the shoulder and head.

(4) To take a size 18 14 radiopaque 12in. catheter out of all its protective wrappings and place it on a sterile towel by the patient's neck. (When sufficiently experienced with this technique, it is much better to leave the protective sheath on the catheter.)

(5) To detach the 2in. 14 G needle and fix it on the 10 ml syringe, already filled with the normal saline.

(6) To elicit the junction of the lateral edge of the clavicular head of the sternomastoid to the upper edge of the clavicle and, after infiltration with 1 ml. of 1 per cent Xylocaine, to insert the intracath needle 1 cm. back (posterior) from this point, aiming below the ipsilateral sterno-clavicular joint. Quite a lot of force may be needed as the needle has a wide diameter.

(7) After penetration of the skin, 1 ml. of normal saline should be injected immediately into the subcutaneous tissue, to clear out any possible plug of skin, which may have been cut by the needle.

(8) The needle is advanced at a 45° angle between the clavicle and clavicular head of the sternomastoid, in the horizontal plane. The vein is found less than $\frac{1}{2}$in. to $1\frac{1}{2}$in. beneath the skin, depending on the size of the patient. It is often more posterior than one might expect and is sometimes easier to find as the needle is withdrawn.

The left subclavian vein, being longer, is, perhaps, easier to intubate than the right but the same technique is used on both sides.

Blood usually flows back rapidly. The patient is told to breathe quietly (to minimise air embolism) and the syringe is detached from the needle and the catheter threaded through the needle. Often it catches in the hub and a slight manipulation is needed to enter the lumen of the needle. If the catheter does not readily pass down the vein, once it is through the needle, both needle and catheter should be removed together, as a precaution against cutting through the polythene, with subsequent catheter embolism.

(9) When the catheter is fully passed, the needle is fixed into the hub of the catheter and the two are withdrawn about 3in., when the tip of the catheter should lie in the superior vena cava. There is a guard for the needle to prevent accidental kinking of the catheter at the point of the needle.

(10) The site of entry is immediately sterilised and sealed with N.S.B. spray. This spraying is repeated on alternate days when it is checked that the end of the catheter is firmly in the hub of the needle. The guard is strapped to the front of the chest to allow full movement of the shoulders and arms and to minimise risk of dislodgement of the needle and catheter. With this method, patients can walk round the ward, supported by two nurses, one of whom pulls a mobile drip stand with the transfusion bottle along with them. The veins in the antecubital fossae are always avail-

able for estimation of the electrolytes without the complication of their being thrombosed by the drip.

(11) The position of the catheter is checked next day by chest X-ray.

(12) The end of the catheter is cultured after removal.

Complications

(1) Though it is easy to hit the pleura, our patients have not so far been troubled by either a pneumothorax or a haemothorax.

(2) The subclavian artery can be punctured if the needle is both superior and posterior to the correct plane. The needle is simply removed and pressure applied to the site for 10 minutes.

(3) Part of the brachial plexus could be hit, but we have had no complaints of root pain.

(4) Air embolism is not a problem, so long as the patient is in the Trendelenberg position.

(5) Local infection and septicaemia are always a possibility.

(6) If the transfusion stops because the intravenous bottle of fluid has run through unnoticed, 5 ml. of water for injection should be injected down the catheter, again taking precautions against air embolism.

(7) If the catheter has been passed too far, it may be in the pulmonary artery and there will be a false high reading. This should not occur if the catheter is pulled back the 3in. and the check chest X-ray performed.

Reading of the Manometer

First the manometer is filled from the intravenous bottle. The tap is then turned so that only the patient is connected with the manometer and not the drip bottle itself, otherwise there will be a falsely high reading.

A simple method is to zero the manometer on the mid-axillary line, where a mark should be made on the patient's skin. The patient lies flat without a pillow.

With a reading of 0-6 cm. this indicates that a patient is under transfused.

6–12 cm. suggests the blood volume is about right.

13 cm. and over means the patient is either over-transfused or in heart failure and extreme care is needed over further transfusion.

The patient must be in the same position for each manometer reading.

This simple method can be used in the general ward and there is no need for any special nursing as is found in most Intensive Care Units.

I am indebted to Mr. Max Pemberton for demonstrating this technique of subclavian intubation to me, and to Mr. A. P. Ross who helped develop this method. Mr. Pemberton first became interested in subclavian intubation following a lecture on Parental Hyperalimentation, by Stanley J. Dudrick, M.D., at Philadelphia in 1968.

Reference :

(1) Hardaway, R. M. The use of plasma expanders. *Hospital Medicine*, July, 1968. 1198-1206.

THE NAVY IS OFFERING TWENTY-FIVE MEDICAL CADETSHIPS THIS YEAR. ONE COULD BE YOURS.

To be in the running, you must have your 2nd M.B. behind you.

After that, we'll want to be sure you are suited to be a medical officer in the Royal Navy.

For it's a unique way of life.

Serving with the Navy at sea, you'd have absolute responsibility for the health of all on board—and possibly in other ships as well. Alternatively, in Naval hospitals at home and abroad, you'd be caring for Service men and women—and their families.

Wherever you are, you'd be part of a team. Finding new interests—meeting new problems—seeing new faces. For as well as being a doctor you'd be a naval officer—with the travel, the satisfaction and the full rewarding life that every naval officer enjoys.

Of course all this happens after your registration. In the first place, to qualify for a medical cadetship, you must pass your second M.B., or equivalent. After that you must be selected, following a Board interview.

Then while still at medical school, you are just like any other student. Except that we pay your fees and give you a guaranteed salary of £1,814 a year in the rank of Surgeon Sub-Lieutenant.

When you qualify you can spend your pre-registration year either at your hospital or one of ours.

After which we promote you to Surgeon Lieutenant, your pay goes up to £3,395 a year and you begin your short-career commission with us for five years. When you leave us you'll take a lot of useful experience with you—together with a tax-free gratuity of at least £1,400.

As well as 2nd M.B. students, the Navy also enters qualified doctors for a 5-year short-career commission. (Applications should be made during or after pre-registration year.)

Write now to Surgeon-Commander F. M. Kinsman, R.N., (26 AZ), Dept. of the Medical Director-General (Navy), Empress State Bldg., London, S.W.6, and tell him your age and qualifications. In return he'll tell you more about the advantages of applying for a medical cadetship or commission with the Royal Navy.

RN ROYAL NAVY

Radio Guy's

D. R. B. M. Young

If you are so bold as to enter the wards of this establishment on Tuesday, Thursday, or Sunday evenings, you would notice an expression of rare contentment on the faces of the patients. Surprisingly enough, it is not all that well known as to the reason behind this strange happiness.

The answer is to be found in various unintelligible sounds which are produced in a small room in 15, St. Thomas Street, and piped to the Blood Transfusion Unit, from which they are dispersed to all the headphones of the patients of Guy's and St. Olave's Hospitals.

As the title of this article might suggest to the intelligent reader, these strange sounds refer to the efforts of the Radio Guy's production team. The radio is staffed entirely by volunteers who endeavour to play musical requests and name checks and generally provide a personal radio service to entertain or relieve the boredom of the patients. They in their turn can communicate through the radio with any other patient in the hospitals.

Our ambitions in this station are modest. We do not wish to produce radio documentaries, local news programmes, rugby football reports or radio bingo; but we want to improve the request shows that we now produce, to increase our library of records and tapes, to have better quality sound reproduction, and then to increase broadcasting times slowly up to seven evenings a week. The last is of great importance for, as a result of the rapid turnover of patients, we are unlike national radio in having no regular listeners. This means that it is a difficult and time-consuming task to keep everyone informed of the existence of the service, and a task in which we are failing at the moment. Our advertising takes the form of monthly newsletters which we take around all the wards. Each newsletter contains programme times, a request form, a note explaining the service to any newcomers, pieces of general chit-chat about the DJ's and any changes occurring in the station. So at the beginning of each month the newsletters are circulated and the result is always the same. For the next week we receive stacks of requests and then the response tails off to virtually nothing until the next newsletter is produced. Obviously, broadcasting seven evenings a week will resolve the problem of advertising so long as programme standards are maintained at a high level.

It is now more than two-and-a-half years since the first test transmission announced Radio Guy's to the world—Guy's is our world. At that time I was still north of the Wash, but I am told that these transmissions were pre-recorded in a small studio in downtown Forest Hill and then transfused to all. Things began to progress after the arrival of the eviction order and, with a good deal of help from the Board of Governors and the Guild of Ex-Patients and Friends of Guy's Hospital (the latter in particular have been very kind), 15, St. Thomas Street was converted and equipped so as to

become the Radio Guy's that we now know. The extension of the service by a G.P.O. landline to St. Olave's a few months later even hit the evening papers—though not the front pages.

One of the great advantages of live broadcasting in the new studio is the "instant request" service. Because studio staff are available on the premises while we are "on the air", patients need simply dial Ext. 301 so as personally to give their requests, comments or abuse and get an immediate response. However, we have not as yet perfected the art of my name-sake's live "telephonio" conversations with fascinating housewives from Llanbedrog, nor do we have a regular panel of Consultants for weekly Dial-a-Diagnosis shows. But we are always progressing; in the near future we hope to make a number of improvements to our studio—plans are being drawn up for a new PA/DJ intercom system, so that any disagreements between staff can be settled verbally and not otherwise; and we shall soon be adding to our library of tapes and records.

So, with everything looking rosy for the future, I would like to invite you all to the studio to browse around, ask any questions and make the coffee. And, of course, any talented increase to our already talented staff would be welcome provided you have got what it takes. In conclusion, I leave you with a statistic with which you may do as you please: "With around 19,000 patients spending an average of 10 days in the hospital each year it would be necessary to keep broadcasting for four hours a day if they all sent in just one request."

A Barkhanocyte.

INCREASE IN SUBSCRIPTION RATE

The annual subscription rate to the GUY'S HOSPITAL GAZETTE has, to the great regret of the publishers, had to be increased by a small amount to meet advances in production costs and greatly increased postal charges which have made the present rate uneconomic. The single copy price of the Journal has been raised at the same time from 10p to 12p.

New subscriptions taken out after 1st November, 1971, will be increased by 40p to £2.50 per annum.

We respectfully ask subscribers, who pay by Bankers' Order, to fill in the form opposite (top) and send this to your bank as soon as possible. We must apologise for this step but we hope you will still continue to support us and to enjoy our journal.

Subscribers paying by cheque are requested to fill in the cash form opposite (bottom) and return this to us.

J. PATTERSON,
Manager.

Banker's Order Form for SUBSCRIPTION

To Messrs. ..... *(Bankers)*

.....

.....

Please pay as an Annual Subscription for GUY'S HOSPITAL GAZETTE now and until further notice, on the ..... day of ..... the sum of **£2.50** to Credit of GUY'S HOSPITAL GAZETTE ACCOUNT, at the Midland Bank Ltd., (Southwark Branch), 28, Borough High Street, S.E.1, and charge same to my account.

40—06—21. **This cancels any previous order.**

Signature .....

Address .....

.....

£2 - 50 *Date*.....

To the Manager,
Guy's Hospital Gazette,
Guy's Hospital,
London Bridge, S.E.1.

Please find enclosed herewith my Annual Subscription to GUY'S HOSPITAL GAZETTE of **£2.50.**

Name (in full) .....

Address .....

.....

.....

Date .....

CORRESPONDENCE

Women, Sherry and Medicine

SIR,—For those whose minds boggled at the thought of an all-female gathering to discuss careers, may I inform them that the evening was a great success!

The meeting was attended by about 80 people and was on a very informal basis. It enabled discussion of the delights and drawbacks of well-known specialities, as well as, and more particularly, introduction to branches of medicine which were previously unthought of.

I should like to thank Dr. J. Fullerton for instigating the meeting, and very generously providing the sherry; also the Medical School for the refreshments and use of the room. A particular thankyou must go to Maureen O'Niel, and Barbara Moulds, for all their work with the invitations and waitressing on the night.

If anyone has any comments which may be useful for further meetings, we would be delighted to hear them.

Do the men feel "left out"—would they like something on the same lines?

Yours sincerely,

LYNNE HAMPSON,
(Student President)

Guy's Hospital Students' Club,
London Bridge, S.E.1.

The Ward Sister

SIRS,—How excellent has the Nursing Section of the *Gazette* become over the last year under Sister Jefferies' pen, but how little response it seems to have evoked from anyone Nursing, Medical, Dental or Ancillary.

We are well able to understand the reluctance of the Nurses in Training to write, in view of the way the *Evening News* pulled pieces from the context of a letter in the early summer to give an erroneous but sensational story, but despite this, could not the Sisters give their opinions? There is likewise no reason why ex-Guy's doctors and nurses who still take the *Gazette* should not make their views known to stimulate activity where it is most needed—in the Royal Colleges. It is essential that the Medical Profession supports, and is widely seen to support, the Nursing Profession.

For a start we think that the Salmon Report was wrong to make the post of Ward Sister a non-incremental one leading to the position wherein a natural "Nurse" must turn from nursing to administration if she wishes to enjoy the privileges, standard of living and pension rights that are her due. Small need to wonder that there is a relative wealth of Junior (one to two years) Ward Sisters and an absolute dearth of experienced Senior Ward Sisters. The real teaching of nursing on the wards is by precept and example and the Junior Ward Sister is too busy learning her art to have time over to teach—if indeed she has learnt enough of the art to have anything worthwhile teaching. The experienced Guy's Ward Sister can run her ward happily with half her energy (I wished, but was not allowed, to say "standing on her head" J.V.K.) leaving ample for teaching and demonstrating the art of nursing. In the meantime there could be a sharing of further teaching on the wards by suitable qualified nursing staff as suggested in the Nursing Section of the *Gazette* on 9th October.

The National Health Service was founded on a misconception. The Beveridge Report assumed that free treatment would lead to prevention and early treatment with a resulting fall in morbidity and an increasingly healthy nation. We think that the Salmon Report is fostering yet another misconception —that the Ward Sister is a lower order of life than the Administrative Sister, one who has failed in her aspirations akin to the General Practitioner who was supposed to be a doctor who had fallen from Lord Moran's erroneous and mythological ladder.

Finally, let those who would rush into print stating that a Ward Sister with a vocation does not want money as her reward; remember how unstuck the Ministry of Health, as it then was, became when it tried that one on the General Practitioners as a bargaining shut-out bid. Every professional knows his or her own worth and it is unnatural to expect a Ward Sister to sacrifice a reasonable income, parity with administrators of equal seniority and a comfortable retirement at the end of her time.

Now, who agrees or disagrees with us? We, anyway, hope that Sister Jefferies will continue to write her thought-provoking articles and we presume that nobody will disagree with that hope!

Yours faithfully,

JOHN V. KILBY, M.B., B.S., M.R.C.G.P.
URSULA E. KILBY, (née Dean) S.R.N.

Kimbolton,
Huntingdonshire, PE18 0HB.
Tel: Kimbolton 205.

Missing Record

SIR,—I would be grateful if the student who borrowed the record of Heart Sounds from the Pre-Clinical Classroom during the last course would kindly return it to the secretary, as a number of the students of the current class may also wish to have the opportunity of using it.

We are planning to increase the number of teaching aids available for self instruction during the clinical period and I am sure the students will appreciate that the success or failure of such a venture will, in part, depend on the co-operation of the students in returning records, slides and tapes to the classroom as soon as they have finished using them.

Yours sincerely,

S. MCHARDY-YOUNG,
Clinical Tutor.

Guy's Hospital,
London, S.E.1.

NURSING SECTION

The Nurse and Technology

During the last few years modern technology has made a very great impact within hospitals. Each day there is yet another new mechanical aid with which the nurse has to familiarise herself, and one is frequently led to ponder on the amount of preparation which has been, and is currently being given for this.

The attitude towards such innovations amongst many senior nurses, and also their medical colleagues, is frequently one of antipathy. How frequently is the nurse in training told that she need not bother about all these machines, and that it would be much better if she acquired perfection in the gentle art of bandaging.

Now, whereas one would not dispute the fact that the traditional nursing skills are still of extreme importance, one must concede that to the student who has just entered the wards, and, finding herself one of only two people on duty when there are patients in the ward attached to pacemakers, etc., these exhortations must have a somewhat hollow ring about them.

Unfortunately, a somewhat retrograde attitude towards progress tends to be perpetuated by the official bodies who determine the nature of training curricula and examinations. It is less than ten years since "Cupping and Blistering" was omitted from the syllabus and not many more since leeches made their exit—to the gratification of all! The pace of advance has admittedly been extremely rapid, but in this case, so too must be that of attitudes.

It is surely time that the profession took a long, hard look at itself. Somehow a satisfactory balance must be obtained. We do not want in this country a situation where the nurses have become too sophisticated to attend to such "trivialities" as the comfort of the patients, as has occurred in America; or on the other hand would it be acceptable for the nurses to be so inadequately trained that they are unable to handle complex apparatus. The equation must somehow be balanced.

At the same time as ensuring this latter it is also wise to remember that healthy criticism is always beneficial. As with any other industry, the salesman of medical equipment will always be most persuasive, and a reputedly time and labour saving piece of apparatus might prove to be most troublesome. In addition, the doctors might be delighted with a new innovation until the impracticalities which they have overlooked are pointed out by the nursing staff.

It is the aim of all in the profession to give as high a standard of care as possible and to ensure the safety of patients; and it is also very evident that greater accuracy in monitoring, etc., has, over recent years, been most beneficial.

Since then, the age of technology has arrived and will remain. It is time that the profession considered equipping their trainees adequately. Somehow, the best of both worlds has to be achieved. If they do not have this, the newly-qualified nurses will feel totally

inadequate when they undertake positions of responsibility.

Nurses who are traditionally so conservative in their attitudes, must surely shed this, in order that they can prove themselves capable of providing the highest standards of care both in the traditional and modern concepts of the expression.

Miss Linda Titley—An Appreciation

On 25th August this year, Miss Titley left Guy's after spending three years as Matron of the hospital.

Miss Titley returned to her own hospital in 1968 at a time when there was considerable instability amongst the nursing staff. During her period in office, it has been most encouraging to see and feel this gradually disappear as a state of balance was restored. In addition, during this time it has been pleasing to observe the increase in the number of trainees of the hospital who are returning to take up senior positions within the wards and departments.

Despite her many commitments, Miss Titley always made herself available for the Ward Sisters: if one required advice or help it was always possible to receive this at very short notice. She would always give a definite decision or helpful suggestion at times when anyone was in doubt. In addition, for anyone who was very worried about problems unconnected with their work, she would always listen sympathetically. At the same time her acute sense of humour would frequently assist in lightening strain.

It is a pleasure to have this opportunity to thank Miss Titley on behalf of everyone at Guy's. She sacrificed three years of her retirement in order to return to the hospital at a time when her influence was greatly needed. We wish her every happiness, and hope that we shall see her as a regular and frequent visitor.

P.M.J.

SPORT

RUGBY

TREDEGAR v. GUY'S

Tredegar 12 pts. Guy's 6 pts.

Having travelled from the rain of Cheltenham through the mists of the Forest of Dean it was a pleasant surprise to find such good playing conditions.

The initial encounters were rather inconclusively played around the centre-line, but after five minutes Guy's forced play into the Tredegar 25. From an ensuing scrum a Tredegar wing-forward was offside and Novak converted the simple penalty. Five minutes later the offence and kick was repeated from an almost identical position. The tempo of the game now increased, and Tredegar spent most of the remainder of the first half in attack, but the Guy's covering defence held, although a little shakily, with Danford and the back row of the scrum outstanding. At the interval Guy's still led 6—0.

The second half started in much the same pattern as the first half and after 10 minutes Guy's conceded a penalty for foot-up in the scrum, which was converted.

The Guy's pack now started playing much more as a unit and dominated the game for the next 15 minutes, particularly with some good concerted foot rushes. However, no score resulted and the momentum slackened. This was noticeable when Novak attempted a long-range penalty kick and not one member of the side followed up.

With eight minutes to go a useful looking movement down the right touch-line ended in a cross kick received gratefully by the Tredegar fly-half, two missed tackles and a failure to fall on the ball swiftly led to a Tredegar try near the corner flag, which was converted. This was followed two minutes later by a penalty from a ruck which was very dubiously given after a Tredegar forward had blatantly gone over the ball.

Guy's lost this match which they could so easily have won, due to a lack of cohesion for much of the game and poor tackling and falling in the centre.

Team: M. Danford, D. Armstrong, T. Drewett, A. Campbell, R. Barough, D. Jones, C. Croft (capt.), D. Rosewell, T. Gibson, G. Evans, D. Stuart, R. Burt, A. Fallowfield, M. Novak, H. Holliday.

C.W.W.

HOCKEY

1st XI v. H.A.C.

at Armoury House, Saturday, 23rd October, 1971.

The Guy's team resplendent in their blue and gold shirts (except for one notable exception), took the field against the Honorary Artillery Company on a beautiful Indian Summer day.

Roger had cautioned us to play hard and fire with all possible power against their big guns.

Play commenced when half of our "back four" arrived. The speed of the opposition in attack, belied their age, but Guy's set up the first real scoring chance.

Burns gave a well-timed reverse pass to Handler, who sped away to the bye-line. Unfortunately, his crisp centre across the face of the H.A.C. goal was somewhat ignored by his fellow-forwards.

The game was very open, in fact too open for the likings of G.H.H.C. This was the telling factor throughout the match. The vast open spaces in the middle of the field were left unattended in the main by Guy's and it was with this free ticket to midfield that the opposition gladly accepted the offer of a victory.

A diagonal pass from their left-winger, split the Guy's defence. The ball arrived at their right wing, and a square pass along the back of the Guy's circle was scooped into the roof of the net, past the dazzled John Cottingham.

Both scorer and goalkeeper admitted later that neither of them had seen the ball.

The Guy's pride was seriously injured and with big Bob Clark steaming through the centre and Roger down both wings, a goal had to come.

It was Charles Crawshaw who instigated the move. A quickly taken free hit was returned to him by Burns. Charles crossed the ball from outside the circle and as the H.A.C. full-back—or grandad as he was aptly called—tried to concede the corner, Handler stopped the ball on the bye-line and passed it back to Burns who coolly slotted it past the stranded keeper.

H.A.C. retaliated with a penalty flick, apparently for a heinous breach of section 18(a) subsection (ii) by John Cottingham.

Half-time arrived and not too soon either. Amidst the ritual orange-sucking and pip-spitting we decided to continue with our still somewhat experimental 4-2-4 formation.

With the sun beating down on our backs, play recommenced, Guy's immediately went into the offensive but unfortunately all the attacks were led down the left wing, and Grandad was still in great form. However, with all our pressure a goal would just not come. As we nearly laid down our sticks in frustration, a piercing run by the opposing right-winger brought out a superb piece of defensive play by our own Phil Nichol.

It was now the turn of H.A.C. to capitalise on the gaps in mid-field. Their good moves down both flanks faded out however, due to the common malaise of poor finishing.

With "Bip" Lakhani trying desperately to organise things in mid-field, aided by spirited running from J.R. and Roger Burns, one would have expected that Guy's could have "pulled one back".

The rest of the Guy's attacks, led principally by the non-stop graft of Bob Clark, fizzled out on the edge of the opponents "D".

It was mainly due to decrease in work-rate, and lack of imagination and common sense, that we allowed H.A.C. to score again.

Lament and despair in the plunge bath evaporated with the coming of the jugs, but Roger Burns is still left with the problem of his 4-2-4 formation.

CLIVE HANDLER.

GUY'S v. MAIDSTONE

Saturday, 9th October, at Maidstone.

Result: Guy's 3, Maidstone 5.

Due to poor travelling instructions from the Maidstone club, the first game of the season began half an hour late, with the Guy's team fielding only ten men, one player having failed to find the ground.

R. Burns standing-in as captain at the shortest of notice, due to the illness of P. Calvert, decided on an attacking plan, with a 5-3-1 formation. This policy appeared to be paying off, despite a poor pitch, more suited to the home team's play, when Maidstone scored twice in quick succession, towards the middle of the first half. The first goal was due to a complete muddle in defence, the second due to a fine piece of soccer by a Maidstone forward. The score remained unchanged despite numerous Guy's attacks, until a few minutes into the second half, when the opposition, against the run of play, took advantage of another bad defensive error to increase their lead to three goals.

It was at this stage that the Guy's attack began to click, and the Hospital promptly replied with a coolly taken goal by Burns. But now, with only one defender covering as Guy's strove to make up the deficit, the side became increasingly vulnerable to breakaway attacks and Maidstone scored twice more from these.

Guy's soon replied to the first of these with a well-struck short corner by R. Clark, and also had the last word when Clark again scored, this time with a superb solo goal direct from the bully-off. This capped a promising performance by a ten-man scratch side and also showed a re-emergence of the old Guy's spirit, with every player pulling his weight.

One was left with the impression that, when fit and fielding a complete side, this could be as strong as any Guy's side over the last few years.

Team: J. Stokes, P. Nicol, C. Crawshaw, N. Matthews, P. Willmer, C. Handler, J. Walker, R. Clark, R. Burns (capt.), R. Forber.

N.P.C.M.

SPIROCHAETES v. FRESHERS' XI

Sunday, 10th October, at H.O.P.

Result: Spirochaetes 2, Freshers XI 0.

A very strong Spirochaetes side, containing no less than eight 1st team players, turned out for this the traditional opening to the Sunday season. In opposition was a useful Freshers' XI, much strengthened by their two "guests"—Roger Burns (who took the honorary captaincy) and Bob Fell.

The game itself proved to be very close and was hard-fought throughout; indeed, some of the tackling would have done justice to a "Cup" game! The Spirochaetes gave a solid, all-round performance, and both their goals were scored by Bob Clark (Jnr.), the second being converted from a short corner.

The Freshers had many chances to reply, mainly due to fine link-work between Roger Burns and Bob Forber (a welcome recruit from the Wanderers). Lack of fitness, however, among the strikers, and the presence of Mike Vellacot in the Spirochaetes defence, repeatedly thwarted their attempts to score. The end result was a fair reflection on the difference between the two sides.

The occasion was marked by the presence of the Club President, Professor R. D. Emslie, and the captain would like to thank him and the other supporters, especially R. Clark (Snr.), and C. Pearson whose "whistle-blowing" enabled Colin Hunter-Craig to keep a firm grip on a game that might otherwise have got out of hand.

Teams: Spirochaetes—J. Stokes, M. Vellacot, S. Hanley, P. Nicol, N. Matthews (capt.), P. Wilmer, I. Cooper, J. Walker, R. Clark, C. Crawshaw, S. Weedon. Freshers—N. Bardsley, B. Lakhani, R. Fell, J. Horton, D. Cole, M. Clapham, C. Handler, R. Burns (capt.), R. Hannaford, R. Forber, M. Bennetts.

Umpires: C. Hunter-Craig, R. Clark (Snr.), 2nd half; C. Pearson, 1st half.

N.P.C.M.

1st XI v. TEDDINGTON 2nd XI

Result: won 2—1

Ten minutes from time John Walker threw his arms in the air and convinced the unsighted umpire that the ball had crossed the line for the winning goal. This was a sweetly struck short corner by Robert Clark which, though deflected on to a post, spun back into the goal.

For the first time Guy's fielded 11 strong players in a new formation. Teddington scored first from a corner but the game was never one-sided and play swung from end to end. Robert Forber and Robert Clark were always troubling the defence and it was a pass from Clark to Burns who gave it immediately to John Walker in the circle that led to the equaliser. Walker met the ball on the run and hit it first time past the 'keeper, who stood no chance.

Although the defence was very shaky at times the standard of play was good, especially Bob Lakhani's save on the post when the 'keeper, John Cottingham, was committed.

If the team can stick together and play like this there should be some good results this year.

Team: J. Cottingham, M. Vellacott, B. Lakhani, C. Crawshaw, P. Willmer, R. Burns, J. Walker, N. Matthews, R. Clark, R. Forber, C. Handler.

SQUASH RACKETS

The squash season has got off to an encouraging start, the 1st team having won 7 out of 8 matches. This has come about largely as a result of two new players, I. Nicholson and R. Sharp playing at No. 1 and 2. As no squash players have left since last season those who were playing at No. 1 and 2 then are now playing at 3 and 4. The last three places being made up from:— P. Calvert, J. Owen, E. Evans, A. Edwards, C. Mackenzie and T. Reynolds—we expect some more names on this list before the season is over! At present the team is missing P. Calvert, who will be away ill for half the season, and J. Lewis who is returning in a few weeks.

The Club as well as playing in the Cumberland Cup has entered two teams for the University League, one playing in Division I and the other in Division III. The competition in Division I is strong, but in Division III it is so variable that it is proving difficult to guarantee good games for everyone; efforts are being made to get into Division II in January.

Results:

Thurs., 7th October	1st v. Baltic Exchange	Won	3—2
Tues., 12th October	Cumberland v. S. Kensington ...	Lost	2—3
Thurs., 14th October	1st (Div. I) v. University College I.	Won	3—1
Tues., 19th October	Cumberland v. N. Surrey ...	Won	5—0
Wed., 20th October	1st v. Royal Vet. College	Won	5—0
Thurs., 21st October	1st (Div. I) v. Imperial College ...	Won	2—2
Tues., 26th October	1st v. Exiles	Won	4—3
Thurs., 28th October	1st (Div I) v. St. Mary's Hospital	Won	3—1

MATCH v. PRESIDENT'S V.

For the second successive year, Mr. Maynard, the squash club president, challenged the captain to a squash match. Last year, the President's modesty about his players' abilities coupled with some intensive pre-match training at Dolphin Square, enabled him to win his own game and, thus the match, by 4 ties to 3.

The original idea was for the match to open the squash season and the date fixed was 1st October. However, this was not possible and so, after considerable discussion, the date agreed was 20th October.

At exactly 5 p.m. Mr. Maynard went on court to play Richard Kinder and after a brief "knock-up" the match began. Mr Maynard opened the scoring but Kinder then got "In-Hand" and, serving very accurately, was soon leading by two games to nil! Mr. Maynard then retaliated with some fine winners (including a couple of body-line specials) to lead the third game 7-3, but at this point, Kinder retaliated and came through to win in straight games.

The next two ties proved to be the longest and closest of the match. In one court Chris Ellis, immaculately dressed and playing some very elegant shots, played Mr. Lallimand. The game was played at a very fast pace and was won by Mr. Lallimand, who was always quicker around the court than his opponent. Meanwhile, in the other court, John Ogle had a very hard fight against Mr. Hill. If this game was not notable for its finesse, it was certainly notable for the physical contact—but what else can you expect from a prop and a lock forward. In the end Ogle won, which put the Captain's team ahead by 2—1.

This was soon changed. D. Thorburn appeared on court to play Tony Edwards and proved to be in excellent form. The first game was close: but from then on Thorburn was very much in command.

And so to the final and deciding tie. It was between Edward Evans and Mr. Barwell. By now there was quite a large gallery and tension was mounting by the minute. However, the two players seemed unperturbed and allowed themselves the luxury of a long "knock-up". When they finally started the scores remained very even, until Evans broke clear to lead 7-4. Barwell retaliated, playing some fine winners and after some long rallies won the first

game. As the match went on he was unable to keep up the pace and lost 3-1 despite a gallant rally in the last game.

So, the result, victory for the Captain's V. by 3 ties to 2 and revenge for the defeat of the previous year. So too, the end of the match . . . but not of the evening. The teams plus spectators adjourned to the Players' theatre where, after an excellent dinner, they relaxed and enjoyed the production "Late Joys".

E. J. E.

HOSPITAL INFORMATION

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited for the post of Tutor in charge of the Introductory Course, with duties to commence mid-January 1972 and appointment until the end of September, 1973 in the first instance. Forms of application are obtainable from the Dean, Guy's Hospital Medical School, and should be returned not later than **18th November, 1971.**

PASS LIST

UNIVERSITY OF LONDON

Doctor of Philosophy (Ph.D.) Science
August 1971

Tatyana Katkov (Biochemistry)

Master of Philosophy (M.Phil.) Medicine
August 1971

Gideon Sein (Pharmacology)

CHANGES OF ADDRESS

Dr. D. N. Anderson, 64 Delamere Road, Earley, Reading, Berks.

Dr. and Mrs. W. B. Clegg wish to announce their change of address to: Mill Cottage, Leintwardine, Craven Arms, Salop. Tel: Leintwardine 288.

Dr A. G. C. Cox, "Iver Lodge", 40, Arterberry Road, Wimbledon, London, SW20 8AQ. Tel: 01-946 1613.

Dr. N. Irish, 2, Esmonde Drive, Troubridge, Ilchester, Soms.

R. G. Notley, M.S., F.R.C.S., 8, Waterden Road, Guildford, Surrey.

Richard and Margaret Notley, "Spindlewood" Pewley Hill, Guildford, Surrey.

Dr. N. A. Watson, 73, Guildford Park Avenue, Guildford, Surrey.

BIRTH

GRAHAM—On 19th September at Queen Charlotte's Hospital, London, to Doreen (née Millar) and Martin, a son, Jonathan Charles Andrew, a brother for Angus.

PAPERS BY GUY'S MEN

Bewick, M. and others. International collaboration in renal transplantation. *Lancet*, 1971, **2**, 228.

Binnie, W. H., Day, R. C. B. and Lynn, A. H. Lymphosarcoma presenting with oral symptoms. *British Dental Journal*, 1971, **130**, 235.

Chlouverakis, C., Jarrett, R. J., Keen, H. and others. Urinary albumin excretion in the offspring of conjugal diabetics. *Lancet*, 1971, **2**, 239.

Clark, T. J. H., Collins, J. V. and Tong, D. Respiratory depression caused by nitrazepam in patients with respiratory failure. *Lancet*, 1971, **2**, 737.

Cooke, S. A. R. Misleading features in the clinical diagnosis of the peripheral glomus tumour. *British Journal of Surgery*, 1971, **58**, 602.

Day, T. K. and Powell-Jackson, P. Fluoride toothpaste. *Lancet*, 1971, **2**, 703. (Correspondence).

Munro, A., Bewick, M., Manuel, L., Cameron, J. S., Ellis, F. G., Boulton-Jones, M. and Ogg, C. S. Clinical evaluation of a rosette inhibition test in renal allotransplantation. *British Medical Journal*, 1971, **2**, 271.

Rees, R. J. W. The fate of *Mycobacterium leprae* in CBA mice. *Journal of Pathology*, 1971, **104**, 77.

Rees, R. J. W. and another. Sarcoidosis and Crohn's disease. *Proceedings of the Royal Society of Medicine*, 1971, **64**, 944.

Tong, D. Haemorrhagic necrosis of the breast complicating anticoagulant therapy and mitral stenosis. *British Journal of Surgery*, 1971, **58**, 624.

BOOK

Longmore, D. B. The heart. Weidenfeld and Nicolson, London, 1971.

GUY'S HOSPITAL GAZETTE

EDITORS A. M. TURNER and J. L. LEWIS
NEWS EDITORS C. G. CHINERY and D. I. F. KELLEHER
SPORTS CORRESPONDENT R. W. BURNS
NURSING CORRESPONDENT Miss P. M. JEFFERIES

FORTNIGHTLY TEN PENCE VOLUME 85 NUMBER 2175

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Mingle, You That Mingle May

"Of course, I have nothing against psychiatrists it is just that as far as I know they never actually help anybody".

It is a common criticism of any hospital undergraduate teaching that it pays too little attention to the prospective careers of the majority of the students; that is that most are about to embark on general practice. One of the most frequently encountered groups of conditions, I say groups of conditions because we are compelled to reify complaining symptoms into mutually exclusive groups of pathologies, is the category of illnesses which the general practitioner treats with what is known as psychiatrists' therapy, or which he refers to a psychiatrist. It might be expected that a teaching hospital would devote a large amount of its undergraduate teaching to psychiatric treatment given the three factors that contribute to its importance, firstly the frequency with which such conditions arise, secondly the intrinsic interest of the subject to medical students, and thirdly the amenability to accurate diagnosis and treatment. One might also expect that psychiatric training would be given early in the medical students' course so that the skill of comprehending how mental illness may present and relate to other conditions would be taught as part of the basic grounding, essential in the first few months of clinical work.

The training at Guy's does not meet these expectations. The excellent teaching departments in adult and child psychiatry share their teaching time with the Ear, Nose and Throat Department, again an essential part of the training, in a timetable which contrives to clash on four out of the ten possible teaching sessions. The psychiatry firm is taken towards the end of the training at a time when, fanciful though this may seem, students' attitudes to patients have already become hardened and it is much more difficult to adapt to a new way of regarding a patient. It can be said that only one thing can be taught or absorbed at a time, therefore it is best to master the ailments of the body before the mind is brought in to compli-

cate matters. That, however, reinforces the split between the two disciplines; it accepts that the mind does complicate matters that are adequately healed quite separately, a concept which is surely inaccurate

The problem is one of administration, not the quality of teaching. The psychiatry firm should not be reduced to half a firm, nor should it find that even with only half a firm's teaching time it is clashing with another teaching department. An excellent compromise could be reached by following the policy, already advocated in the Gazette, of ten week firms, uncluttered by clashes, which would allow greater concentration of teaching time in all subjects apart from general medicine and surgery. The benefit of a clearer understanding in psychiatry and other subjects regarded as peripheral would compensate that loss with great ease.

Lastly, it is necessary to consider the quotation given at the beginning. Certainly the statement expressed by that sentence is less often encountered nowadays, but it is still found even in the medical profession. Until such an ignorant view of psychiatry is dispelled, it is hard to see how our profession can hope to become balanced.

The B.S.T. Blues

British Standard Time is now a thing of the past. Gone are the days of darkness at 9.00 a.m. when children walked to school carrying torches in the hope that oncoming cars might swerve to avoid them. No longer is Radio Luxembourg on the air until 3.00 a.m. The act of wakening entailed groping for unseen light switches and negotiating staircases with invisible obstacles. Dark mornings were cold mornings and the rush-hour seemed eerie in the dawn light.

Times have changed and the struggle to get to work or to school is now carried out in full daylight. Farmers are grateful for the morning light and schoolchildren can walk without torches. As far as most people are concerned, cold autumn mornings are still cold autumn mornings even if they are sunlit.

B.S.T. was introduced as a measure to cut down evening rush-hour accidents and to bring British business hours in line with those on the Continent. The public was very concerned about those schoolchildren and the farmers were concerned about their cows. Meanwhile M.P.'s debated whether people should be at maximum risk in the morning or in the afternoon. Above all, nobody liked those dark mornings.

Britain is in an unfortunate situation because, unless the Earth's axis shifts, there are not enough hours of daylight in winter to please everyone. Since most road traffic accidents occur in darkness and in winter, the ideal situation involves having both rush-hours in daylight. Neither B.S.T. or G.M.T. can provide this and shortening the working day is in the realms of fantasy. However, there are other accident factors which do not depend on daylight. There are junctions which are so poorly controlled that jams and short tempers are inevitable. Nader's Raiders have pointed out how unsafe most American automobiles are and there is no reason to think that British cars are any better. The facts that 5 per cent of cars stopped

at a recent police check-point had defective tyres and that few motorists make use of their seat belts indicate that it is easy to inform but difficult to educate the public on road safety. B.S.T. was a noble idea, but could never make travel less dangerous.

White Coats

At last white coats will be compulsory for all but final year clinical students at Guy's. To some this is a welcome decision while others are indignant at being forced to buy coats which they do not want. Any decision of this kind is bound to cause considerable argument among students. However, unlike the disastrous white coat "experiment" a few years ago, the Medical School has made detailed preparations for both the supplying and the laundering of the coats. There is no reason why the plan should not succeed, yet one hopes that there will be open discussion about its inevitable teething difficulties.

Clinical Lectures

In addition to the customary clinical lectures, Dr. Joiner has organised a systematic course in clinical lectures which in their present series will cover the cardio-vascular system. The lectures are intended as an aid to study of clinical medicine; to be regarded as an adjunct to ward work and information gained from books. They are a welcome addition to Guy's clinical teaching programme.

GUY'S DIARY

NOVEMBER

22	M	5.30	The Scientific Basis of Medicine.* Dr. CALNE. "The Clinical Pharmacology of Levodopa." Part I.
23	Tu	1.00	Clinical Lecture. Professor POLANI. "Pre-Natal Diagnosis by Amniotic Cytology."
		5.00	Clinical Medicine.* Dr. GOULDING. "Acute Poisoning."
		6.00	Update.* Dr. HARRIS and Dr. LEATHAM. "Pacing."
25	Th	1.00	Clinical Lecture. Dr. SOWTON. "Abnormalities of rhythm and abnormalities of conduction."
26	F	1.00	Clinical Lecture. Mr. O'FLYNN.
		2.15	Combined Round. Dr. HUNTER. In the pre-clinical Classroom.
29	M	5.30	The Scientific Basis of Medicine.* Dr. CALNE. "The Clinical Pharmacology of Levodopa." Part II.
30	Tu	5.00	Clinical Medicine.* Dr. KELLY and Dr. SPENSER. "Head Injuries."
		6.00	Update.* Dr. EMANUEL and Dr. ROSE. "Valve replacement in the 1970's."

DECEMBER

2	Th	1.00	Clinical Lecture. Dr. JOINER. "Hypertension I."
3	F	2.15	Combined Round. Professor SIMPSON. "Death From Cold, A Symposium." In the Physiology Theatre. All students welcome.

NEWS IN BRIEF

Wearing of White Coats

Subject to confirmation by the Council of Governors later this month, the School Council have decided that Clinical Medical Students must wear white coats, which they should buy for themselves, and that the School will meet half the laundry charges for up to 40 washes per year.

No restriction has been placed on the wearing of white coats outside the wards.

This decision will take effect on 1st January 1972 but for students at present in their final year the wearing of white coats will be optional.

White coats should be full ones similar to those worn by Residents, and Messrs J. and L. Armitage Ltd. (Tel: 01-639 0539), who already supply a number of the Medical School Departments, have agreed to sell white coats to students at Guy's at £1.47 each (£1.69 for special sizes). Standard sizes range from size 34in. to size 46in. (chest) rising by 2in. sizes. These prices will be operative until 1st January, 1972. Messrs Armitage's representative will be available in the Table Tennis Room, East Wing, from noon to 2 p.m. on Tuesday, 23rd, and Thursday, 25th November, and students will be able to place orders or buy white coats by cash or cheque then. The firm will also be available in the East Wing on further occasions in December as necessary and details will be announced in advance; but it is important that the firm's visits should be kept to the minimum in view of the special terms they have agreed.

The School has made arrangements with the Manor Laundry, whose shop is just south of Newcomen Street, at 155 Borough High Street, to launder white coats for 11p each; and this price will not be increased before the end of 1972.

From the second half of December onwards, cards for 20 washes will be on sale at the Medical School Accounts Office for £1.10 each, and medical students may purchase one of these cards every six months during their clinical period.

The Students' Club Council have endorsed the School Council's decision and the arrangements set out above.

Guy's Turns Detective

The services offered by the Department of Medical Illustration, and pathologist Dr. Keith Mant, have recently been used in assisting the police.

The task involved reconstructing the facial likeness of a young man, aged 29, from the skull of a skeleton found, bound hand and foot, in a shallow grave near Burton-upon-Trent. Medical artists Miss P. Archer, Miss G. Bradford, and Mrs. A. Christie each, separately, reconstructed the dead man's face. The results, which corresponded closely, have appeared on television and in the national press.

Work has now started on the skull of the Leatherhead golf course murder of 3 years ago, and it is hoped to include more information about this process in the next *Gazette*.

Students' Bar

Following the recent resignation of Ted Barrow from the position of Students' Club Bar Steward, the Students' Club and the Medical School have been fortunate in securing the services of Mr. Les Day.

Mr. Day retired earlier this year, having worked in the wine trade most of his life, culminating in the position of Sales Director to John E. Fells and Sons, Wine Merchants, of Tooley Street. He has taken the job to help pass his spare time in his retirement, and it is to be hoped the job doesn't take up all his spare time.

The bar will return soon to normal running, with hot pies available in the evening. Should the finances of the bar improve over the next three months, lunchtime opening will be considered.

Alexander Broido

Mr. J. R. Hudson has recently been in Israel on a lecture tour and during his stay in Jerusalem he was able to contact an old Guy's man, Alexander Broido, who qualified from Guy's in 1923. He asked that Mr. Hudson should remember him to all his friends at Guy's Hospital.

Guy's Man at St. Thomas's

J. S. M. Beales M.A., M.B. (Cantab), M.R.C.P., D.M.R.D., F.F.R., has recently been appointed Consultant Radiologist to St. Thomas's Hospital, S.E.1.

Death

by

Marcus Pembrey, M.B., B.S., B.Sc., M.R.C.S., L.R.C.P.

Towards the Concept of Appropriate Death

My intention is to consider the subject in three parts:—

Firstly, to take a close look at the current attitude towards the dying patient and his management, and also the attitude towards scientific investigations of the dying.

Secondly, to consider some of the recent surveys carried out to investigate attitudes to death and factors that influence these attitudes.

And finally, to consider the possibility of using the information gathered from these investigations to help the doctors deal more appropriately with the dying patient.

It is impossible to state that any ONE attitude exists, but it IS possible to say that a particular attitude is either prevalent or rare; that the management of dying patients commonly reflects one particular attitude to death.

The common attitude is to consider the subject of death as slightly taboo—to avoid the question of death and avoid the dying. This attitude is by no means confined to those who care for patients, but is part of a general attitude towards death. In the past, death in the home was all too common, and its existence could not be avoided, religion served to present death in a manner that was not too fearful to consider.

Now the emphasis is on "living", on longevity, on life-saving drugs and operations.

To quote *Robert Fulton:* "Death now becomes an infringement upon our right to LIFE, liberty and the pursuit of happiness! We cope with it by choosing to disguise it and pretend it is not the basic condition of all life." Incidentally, he backed up this statement by reporting a survey of protestant clergy in America, the majority of whom stated that the major function at funerals is to attend to the living and their needs rather than to the departed dead.

This trend towards neglecting the "act of dying" for other more objective studies such as clinical investigations and Post Mortem History is reflected in a little survey I did into the past and present Post Mortem forms at this hospital. Firstly, the pathologist when making the final records finds it satisfactory to omit the section "Mode of Death" that appears on the form that students may or may not fill in at the P.M. In 1966, only 8 out of the 25 reports made even the slightest reference to the mode of death. In 1936, 16 out of the 25 made reference to the mode of death, although admittedly these were sometimes scanty.

mps

medical protection society est 1892

Unlimited legal aid and indemnity against professional hazards throughout the world (except U.S.A.)

Secretary Dr. H. A. Constable. Head Office
50 Hallam Street, London, W1N 6DE. Tel: 01-580 9241
or Regional Secretary Dr. P. G. T. Ford
Regional Office: 30 Park Square, Leeds 1. Tel: 0532 42115-6

An example is of patient F.R., who died on the 16th July, 1935. The report concludes: "The general condition did not improve, the patient sinking into coma and dying quietly at 1.30 on 16th July."

This avoidance of dying and death occurs throughout the hospital. On the wards the attitude may be most inappropriate, indeed almost irreverent, although not intentionally so. For example—one day I went on to a particular ward to take some blood off a patient. On enquiring where he was I was informed by a staff nurse and houseman, "Oh, that's an awkward question, he's just gone out feet first—*sorry foot first" (he had had an amputation).* These people were not hard, callous individuals—they were just dismissing something they had never really considered. This response stems from being unfamiliar and ignorant of what is involved in the act of dying. I believe that scientific investigations rather than producing a hard, callous attitude towards the dying, will enable us to deal more appropriately with the situation.

I quote only my personal experiences, but many authors report a similar attitude to death and the dying. *Cicely Saunders,* in her article in one gazette, refers to the "more or less subtle withdrawal from real contact with the patient that occurs when the doctor decides 'there is nothing more to be done'." *Cappon,* in 1959, said: "As the living avert their eyes, the dying remain little understood nor helped beyond nursing comforts."

Until recently we were content to disguise death with euphemisms and impersonal rituals, but now medical and technical advances rather than solving the question of death, have forced us to consider it more deeply.

Some years ago many learned men held a symposium at the London Hospital to decide "What is Death." As expected, they came to no satisfactory definition—they are still not sure when they should stop the respirator and let a patient die—whether a laboratory animal maintained on artificial lungs, heart and kidneys, but without a brain is actually alive or not.

Some time ago a nurse, writing in the "Nursing Times", questioned the principle of resuscitation in an elderly patient whose heart had stopped. "Was it right for me to have started resuscitations? Should I have left her to die peacefully? Should her children have been subjected to the mental anguish of watching their mother die slowly and with all that equipment surrounding her?"

This awakening to the problem of dying, this tentative challenge of our frightened attitude to death, can only be good—but for it to be fruitful, I believe, there must be a fundamental change in our approach. These problems are not just physiological, but psychological, social and even moral. So often our manner of approach prevents us from viewing altogether the various components of the problem.

I am presenting this paper to the Psychological Society, because I believe the act of dying to represent the very height of psychosomatic inter action. Only with a psychosomatic approach will we begin to understand and help the dying.

These few words from the Introduction of the London Hospital Symposium on "What is Death"—although it is proposed to avoid philosophical discussion—demonstrate well the reluctance there is amongst scientists to consider any topic in which there is a large subjective element or where value-judgments have to be made. Our teachers are largely responsible for maintaining this attitude and for this they have been criticised in particular by *Sir Robert Platt.*

In an article on Medical Education, he states: "The University whole-time clinical departments have helped the scientific understanding of disease, but it can hardly be said they have helped the understanding of man. Patients are selected to illustrate the scientific aspects of medicine in which the teachers are interested. Nobody studies the man himself. Even psychiatrists often seem to be as afraid of human emotion as the rest of us. Looking back, people will say that even in 1965 there was hardly a teacher who could talk about sex except in biological terms." I think the Tomkinson-Stafford Clark Sex Talks answered that particular criticism then; but what teacher gives a clinical lecture on Death and Dying, other than to consider topics like—"Analgesics in the terminal case?" Sir Robert Platt would argue that they are afraid to handle a subject of such emotional content. Indeed, this fear may stem from their own fears about death and dying.

I cannot agree altogether with Sir Robert Platt, for in his article he implied that human emotions cannot be subjected to scientific investigations. I believe they *can*—to a limited extent—particularly in the case of death attitudes, where the universal fact of death serves as a "fixed point", a standard from which some comparisons can be made. Observations can be made and recorded, deduction can be made from these observations and further action can be modified by these deductions.

I feel it is important that these investigations should be properly planned with careful selection of the "study" and "control" groups of patients. The observational data should be presented in a more or less formal manner, so that others may easily scrutinise the work.

Cicely Saunders' article, "The Care of the Dying," reflected her deep understanding and experience of the dying patient. It served to make us think again of our own attitude, but it did not further the STUDY of the dying patient. She has clearly learnt by experience how to deal with the problems of many dying patients, but she gives no concrete information to help us to deal with them. At times she uses phrases like "Total Pain", the true meaning of which is probably only known to herself. She is not communicating on a scientific level. Some recent investigations however have gone too far the other way, almost every statement is followed by a reference. I actually read the following in one paper—"Even though death and dying are events that happen to each of us" (Fiefel 1959).

It is necessary, before reviewing some of the literature, to present a working hypothesis about which some of the investigations can give us information.

(1) My first assumption is that, barring very young children, we

all have "Death Attitudes", which may or may not be expressed at a conscious level.

(2) These attitudes are influenced to some extent by environmental factors; and groups with similar attitudes correlate to a greater or lesser extent with other groups based on personality traits, age, religion, etc.

(3) That your Death Attitudes dictate to a large extent the manner in which you face your own death and the death of your patients.

The existence of a Death Attitude is often taken as a basic premise in psychological discussion. *Freud*, in his book "Beyond the Pleasure Principal", develops the theme that all "ego instincts" are directed towards achieving an appropriate death, whilst "sexual instincts" offset this with the aim of continuing life through procreation.

There is some controversy as to when a child develops a concept of death, particularly his own death.

Nagy states that "When the child reaches 9 or 10, with the newfound sense of casualty and morality, death is recognised as a process which takes places in all of us. By then, children know that death is inevitable." Annah Freud would support this age. *Wahl*, 1958, suggests that a fear of death can occur as early as three years. It would be useful to quote a case from *Dr. Mac Keith's* book, "The Child and his Symptoms."

Brenda V., a girl aged 4½, could not get off to sleep at night, would not be left alone and was too frightened of traffic to go shopping with her mother. The symptoms date from a minor traffic accident when Brenda's mother had been knocked down, fainted, and was taken to hospital. At the end of the case, they report, "She said, 'I thought mummy was dead, I was frightened. Dead is when you are no more'." This little girl recognised that her mother could die, but whether she knew that she too could die, is difficult to judge.

Weisman and Hackett have emphasised that there are several dimensions to the concept of death and dying—they distinguish IMPERSONAL, INTERPERSONAL and INTRAPERSONAL elements in the experience of death.

Impersonal Death

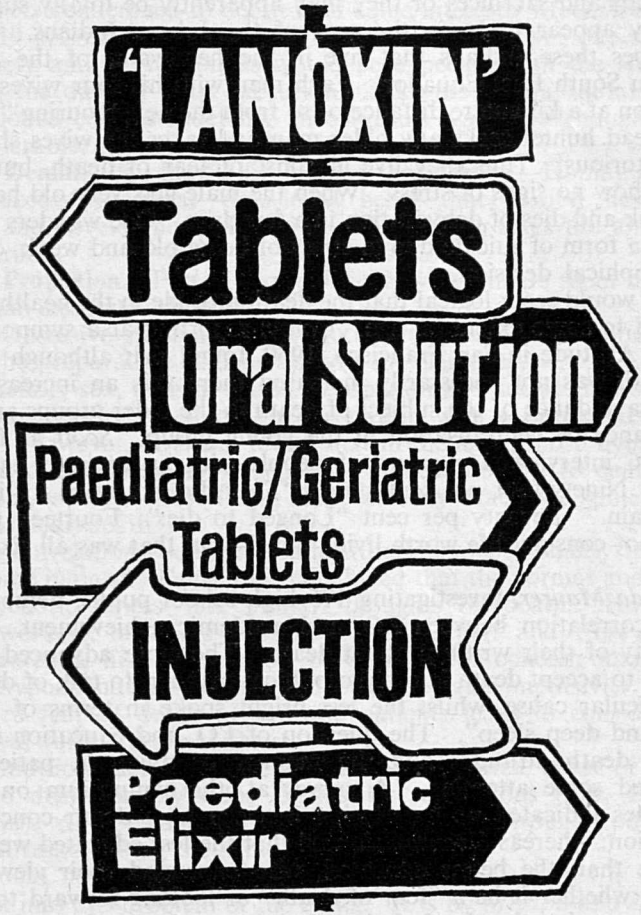
In this view death is an impersonal event, stripped of the human element and the dead are simply dead bodies—specimens for the pathologist. Dead animals and plants are viewed in this way. I think a child appreciates this dimension of death when he squashes an insect against the window pane. Weisman and Hackett mentioned the following—I quote—"Seeming impersonality may also occur among dedicated physicians who acquire 'Professional Attitudes' towards death and disease as the only possible means of coping with disaster daily."

Interpersonal Death

This orientation is concerned with the objective part of death of the "other one". While impersonal death refers to "IT is dead", interpersonal death means "SOMEONE is dead". Death of another one foreshadows our own.

'Lanoxin': whenever digitalis therapy is indicated

Whatever the contingency there is a 'Lanoxin' preparation to meet it. Quality control throughout manufacture ensures pure, precise doses of digoxin in all presentations. **'Lanoxin' Digoxin** brand



Full information is available on request

Wellcome

Burroughs Wellcome & Co.
(The Wellcome Foundation Ltd.) Dartford, Kent

Intrapersonal Death

This is the only dimension of death that really matters. It applies both to the process of dying, particularly the fear of dying, and the fact of subjective death. It will be this dimension of the death attitude with which the subsequent surveys will be most concerned.

As yet, very few comparative studies between different races on their death attitudes have been carried out. Most primitive societies tend to fear death other than in battle. These fears may be acted out in rituals and sacrifices or they may apparently be totally suppressed as they appear to be in the case of the Jobaro Indians. Schmidt describes these Indians that live in the headwater of the Amazon river in South East Equador. Each man with his four wives lives in isolation at a kilometre distance or so from the neighbouring "family". The head hunter seeks any older man and takes his wives should he be victorious. Thus they live in constant fear of death, but apparently show no signs of stress. When the male gets very old he refuses to drink and dies of dehydration in a few days. One wonders whether this is a form of suicide due to stress of being old and weak, or just a philosophical decision.

It would seem logical that the death attitude in the healthy would depend to some extent on age. *Corey*, reporting at a symposium on Death Attitude in San Francisco, 1960, found that although the fear of death was not necessarily increased there was an increased conscious avoidance of the subject of death in the older groups and more acceptance or neutralisation in the young group. *Scott* as far back as 1896 interviewed a group of people with an average age of 76 years. Ninety-four per cent stated "They did not want to live their life again." Seventy per cent "Longed to die." Fourteen per cent "Did not consider life worth living now"—but that was all sixty years ago.

Ada Maurer, investigating 175 high school pupils, demonstrated some correlation between I.Q. and academic achievement, and the maturity of their writings about death. The more advanced student tended to accept death in a philosophical manner, to talk of death for a particular cause, whilst the less bright spoke in terms of "ghosts, fears and deep sleep". The question of I.Q. and education in influencing death attitudes and the manner of dying in patients has attracted some attention. A survey at the symposium on Death Attitudes indicated no correlation between high death concern and education; whereas *Swenson* showed that the less educated were more evasive than the better educated, who expressed their views more readily whether it be a "fear of death" or looking forward to it.

A question that is of obvious importance is the place of religious belief in the attitude towards death. Logically, if a patient really believes in God and an after life, this excludes much of the fear of dying. However, it appears that for many their faith is not strong enough. *Fiefel* 1959 reported that religious persons fear death more than non-religious ones, whereas *Alexander* and *Alderstein* 1959 suggested that death anxiety was aroused more rapidly and with less direct stimuli in non-religious persons. Swenson reports results that

are directly opposed to those of Feifel. He states that "Persons with more fundamental religious convictions and habits look forward to death more than do those with little religious activity". Fearful attitudes tend to occur in those with little religious activity. These discrepancies are no cause for despair, clearly better surveys must be planned. A thought struck me when I was first confronted with these conflicting reports: which of the two authors, if either or both, believes in God and an after life?

I mentioned the phenomenon of denial and in this respect a study of prisoners condemned to death is of some interest. *McGahee* interviewed 19 prisoners in the Sing Sing death house. Not one showed the anxiety and depression as would be expected with the stress of knowing the date of your execution. Like the Jibara Indians they all developed complete defence mechanisms against a thought that was intolerable. Three methods were prevalent :—

(1) **Denial.** "So they'll kill me and that's that."—Hoping always for a successful appeal—delusional belief that pardon has been granted and development of religious ideas of an after life and ultimate pardon.

(2) **Projection.** Persecutary delusions which made them martyrs rather than dissolute criminals.

(3) **Obsessive rumination.** Thinking furiously about minute details in the preparation of their appeals for clemency.

Generally sex, marital status, occupation and social environment have been reported to show no correlation with a particular death attitude. However, *Swenson* found that in the aged, those living in a family or old people's home generally looked forward to death and accepted it, whereas those living alone actively evade the subject and tended to fear death.

The correlations between death attitude and personality makeup are of some interest. *Feifel* 1955 concluded that the normal and those with psychotic illness had similar thoughts on death. However, several workers, including *Weisman* and *Hackett* and *Corey* have demonstrated a high correlation between death concern and traits such as hypochondriasis, hysteria, dependency and impulsivity. This heightened fear of death in neurotic patients leads to considerable withdrawal during terminal illness.

In addition there are several well-authenticated cases of being scared to death and Voodoo deaths by suggestions (*Fry, Barker, Mathisetal*). It appears that these are mediated through continued abnormal responses of the sympathetic system.

I would now like to mention a paper that introduces a wholly new facet into this problem of the dying. It is by *Morton* and *Leiberman*, Chicago, and I quote : "The author's interest in examining psychological changes preceding death was stimulated by the observation that the chief nurse in a home for the aged could predict the death of residents with remarkable accuracy several months prior to any marked physical changes. Nevertheless, she could identify no regularities in the pattern of change, nor any clues other than the fact a person nearing death 'just seemed to act differently'."

They reviewed the literature for evidence of general psychological changes that precede death. *Biegler* 1957, using clinical interviews detected increased anxiety several months before death. *Kleemeier* 1961 noted an intellectual change in an aged population approximately two years prior to death, and this was supported in a further study by *Jarvick* and *Falek* 1963. *Obvist, Henry* and *Justiss* 1961 demonstrated E.E.G. changes preceding death.

Leiberman tested 25 aged subjects every three to four weeks for $1\frac{1}{2}$ years. He did a battery of tests which included Bender Gestalt figures, Draw-a-Person test, and simple projective tests. Those who died during the experiment were termed the Death Imminent group (D.I.), and those who survived at least a year after the experiment were called the Death Delayed group (D.D.) The results showed the following:—

(1) The average response of the two groups was equal at the onset of the experiment.

(2) The D.I. group declined significantly with low performance on the Bender Gestalt drawings and with less complex Draw-a-Person tests. The D.D. group remained constant.

(3) Changes occurred in the D.I. group six to nine months prior to death, often before obvious physical change.

(4) The *change* in performance, not the absolute level, correlated with the D.I. group.

(5) Serious, but not terminal illness did not alter the performance of either group.

I feel no definite conclusions can be made from such a small survey, but the results suggest the possibility of a general dying process that is perhaps an extension of the ageing process. This dying process may in addition to having psychological effects, make the subject more susceptible to death by various old age diseases. This process, rather than social isolation, may account for some cases of withdrawal in the dying patient.

The final paper I wish to consider takes us on to the question of management of the dying patient. It is entitled "Three processes of dying and their behavioural effect"—*Kenneth Chandler.* The summary he gives at the end will serve to illustrate the essential points. I quote:—

"Differing processes underlying dying may serve to clarify the behaviour of those facing death. From the study of groups who were dying differently three major processes are delineated, each with its own behavioural effect. Marked differences in interpersonal transactions occurred depending upon which process of dying was operative; that is (a) the existence of death, (b) the presence of death, (c) the presentiment of death. The presentiment of death gives rise to patient-nursing staff-family behaviour that is characterised by acts of aggression, negativism and withdrawal. Such a process enables a 'bind' to be established between patient and those concerned that is increasingly disruptive and mal-adaptive. Suggestions are made concerning an approach to more meaningful communication with those dying."

They distinguished the three processes as follows:—

(1) **The Existence of Death.** This affected individuals not ill and leading productive lives.

(2) **The Presence of Death.** Concerned patients who are aware that they are going to die, but after an elapsed period of time, i.e. terminal cancer and some multiple sclerosis patients.

(3) **The Presentiment of Death.** Operated in-patients, whose illnesses are such to lead them to expect to die at any moment, that is chronic cardiovascular and cerebrovascular patients with histories of many crises. Only in the last group did they have hostility, aggressiveness and acting out. Both patients *and* staff would contribute and *both* used the phrase "They could do a lot more, but don't."

Chandler suggests skilled assessment of the patient's psychological status, followed by treatment based on the insight provided by this investigation. For the "Presentiment of Death" patients, he suggested that treatment should consist of (1) being consistently available to listen, to be with, in silence and anger. (2) Being available, not to be manipulated by the patient, being stubbornly persistent in being present and demonstrating to the patient indestructibility—able to withstand their terror, their fright and their assault.

Quint and *Strauss* 1964 suggest that skilled psychological assessment be extended to include nursing staff, the medical staff. and the family, so as to enhance the significance of communication with those dying, through effecting changes in those with whom the patient has contact.

It appears that to effect the treatment recommended a full-time psychiatrist will be needed on most wards. However, some simple important facts come out of this valuable paper.

Firstly, it is not the terminal cancer patient who knows he will die after an elapsed period of time, but the "chronic coronary" who is well now but may drop dead any minute, who suffers most from hostility and aggression. All too often it is this group that do not get the sympathy; the medical staff do not tend to think of them of "near to death" as the patient with a liver metastases who may live six months or more.

Secondly, the nursing and medical staff can also contribute to the hostility and aggression by asserting that "They could do a lot more, but don't."

Finally, a change in the attitude of the medical staff can enhance the significance of communication with those who are dying. To make an appropriate change in the attitude of the medical staff is my aim. Their aim should be to help their patients achieve a secure and peaceful ending to their lives. They should not die in isolation. for it is not death. but *how* they will die that they fear; and as *Jean Rene Treanton* said, "The problem for each of us is how not to die alone." We have to communicate with them, not only talk but understand why they behave in a particular manner. The withdrawal of a patient is likely to hide an intense fear of dying. With hostility in a coronary case, hostility in the nurse looking after him can indicate that he is experiencing "Presentiment of Death" as described by Chandler.

Recognising these defence mechanisms we must be ready to broach the subject of death and dying should it appear appropriate. Feifel has remarked that many old patients have thanked him for opening discussions on the subject of death. These discussions must not serve to impose *your* death attitude on those who are dying. Your death attitude has now to be sacrificed for one of tolerance where you appreciate all the various attitudes to dying and what they can mean to the patient. The idea is not to change your patient's opinion but by adjusting yours, make the communication with them more meaningful. Help them to die in a manner that is appropriate to them. It is inappropriate to talk of God to someone who does not believe in the existence of God; in the same way you are neglecting the needs of a religious patient by not suggesting and allowing a priest to attend him.

Weisman and Hackett supported the idea that to achieve an appropriate death all dimensions of the dying process have to be suitably adjusted. Intrapersonal death can never really appear appropriate. No one can face the fact of subjective obliteration. The interpersonal aspects of death must be suitable. Their death must appear appropriate to those they leave behind, their family, their friends. They must have released and transferred their responsibilities. Impersonal death, as indeed their life, must appear as a significant event to the group in which they lived and worked. The doctor, nurse and family can go a long way to achieving the harmony of these three dimensions and help the patient to feel that his death viewed in its whole dimension is appropriate. The fear of subjective obliteration can be minimised by talking to them, not only about their living friends and family, but those already dead. The fact that the dead can bring them happy memories, allows them to feel that something about them will remain after their own death that will not be forgotten.

I believe that it is the patient's attitude that must direct your management. This is almost the exact opposite to some current opinions. On suggesting this to a psychiatrist, the first reaction I got was, "Oh, but you can't—his depression (presumably his first interpretation of a fear of death) may be purely a result of raised bilirubin or something."

Are we to continue to consider the dying patient as incapable of making any decisions about his own life or death, or will we assist him to achieve what his attitudes, his family, his health and his whole life situation directs him to do?

At the symposium on "What is Death," I suggested that in people who are in constant risk of another coronary and cardiac arrest, a decision about whether or not to resuscitate them should be made *before* the event rather than in the three minutes available between "arrest" and death. This assessment could then include their full medical prognosis, their own attitudes, and their social environment—it may be that not to resuscitate would be to achieve an appropriate death.

"We cannot act like God" was the great man's reply. Are we not acting like God when in order to suppress our own fears of death we deliberately choose to save everyone only to let them die alone?

The problem for each of us is how not to die alone. One day that will become a reality for each of us.

References :

C. Saunders: "The Care of the Dying," Guy's Hospital Gazette, March 1966.

D. Cappon: "The Dying," Psychiatric Quarterly 1959, **33**, p. 466.

Symposium: "What is Death," London Hospital, Winter 1966.

S. Freud: "Beyond the Pleasure Principle," 1920.

M. H. Nagy: "The Child's Theories Concerning Death," Journal of Genetic Psychology 1948, **73**, p. 3.

Annah Freud: 2nd Sarah Stolz Lecture, March 1966.

C. W. Wahl: "The Fear of Death," Bulletin of the Menninger Clinic 1958, **22**, p. 213.

J. Apley, R. Mac Keith: "The Child and his Symptoms," 1962, p. 71.

A. D. Weisman, T. P. Hackett: "Predilection to Death," Psychological Medicine 1961, **23**, p. 232.

Schmidt: "Psychological Death in Head Shrinkers," American Journal Psychiatry 1964, **121**, p. 510.

Carley: "Symposium on Death Attitudes," San Francisco 1960, quoted in Journal Gerontology 1961, **16**.

Adah Maurer: "Adolescent Attitude Towards Death," Journal Genetic Psychology, September 1964, **105**, p. 75.

W. M. Swenson: "Attitudes Towards Death Among the Aged," Minnesota Medicine 1959, **42**, p. 399.

H. Feifel: "The Meaning of Death," New York 1959. "Attitudes of Mentally Ill Patients Towards Death," Journal of Nervous and Mental Diseases, 1955, **122**, p. 375.

Alexander and *Alderstein* 1959: quoted in Journal Gerontology 1961, **16**.

McGahee: "Impending Death by Execution," American Journal of Psychiatry, November 1962, **119**, p. 393.

Fry and *Barker*: "Scared to Death," British Medical Journal, September 1965, **5461**, p. 591.

Morton and *Lieberman*: "Psychological Correlates of Impending Death," Journal Gerontology, April 1965, **20**, p. 181.

K. A. Chandler: "Three Processes of Dying and their Behavioural Effects," Journal of Consulting Psychology 1965, **29**, p. 296.

Based on a paper read to Guy's Psychological Society in 1966.

NURSING SECTION

Forty Hours—And Then?

Within three months, the nurses of this country will be obliged to reduce their number of working hours to forty a week. At the same time it is proposed to introduce overtime payments for all concerned.

Apart from the fact that the reduction of working hours will, in an average ward, reduce the amount of nurse time available to the patients by approximately one day each week, there is also to be considered the problems arising from the introduction of payment for overtime working.

It seems quite apparent that nurses are going to be required to spend more than forty hours in the wards each week. It is impossible at present to provide adequate standards of nursing care, and thus the situation appears doomed to become worse. Even now, Ward Sisters work many hours more than they should in order to endeavour to ensure at least a modicum of care. This is all done voluntarily and no acknowledgment is even made verbally in most instances, quite apart from financially. However, now it will become incumbent upon trained staff to request their students to remain at work instead of sending them off duty and remaining behind themselves.

The difficulties inherent in this immediately become apparent, and several questions arise. How many extra hours should student nurses be expected or allowed to work? Conversely, will the authorities attempt to dictate to trained staff how many hours they should work, and refuse payment for any surplus? How will the practical problems be surmounted?

Firstly, one has to appreciate that there is amongst trained staff much resistance to the whole conception of overtime payment. It has always been accepted that one works for as long as is felt personally to be necessary and that as a professionally trained individual this right should not be usurped. Moreover, the privilege was held to work for shorter periods of time when it was convenient in order to balance the time lost. Many will resent any jurisdiction to remove this system, although one could of course argue that due to the acute staff shortages it is never possible to compensate for the extra time worked.

In reference to the question of student nurses it would of course be interesting to learn their views. One imagines that if extra money is the reward they will be quite content to work longer. However, it is surely important to ensure that they are not in any way exploited.

Again, as far as trained staff are concerned it is to be hoped that individual Ward Sisters will not be informed that they should not be working for longer than a prescribed number of hours.

Finally, with regard to practical application, one wonders how it will be feasible for accurate records to be maintained, considering the difficulties currently experienced regarding extra duty payments.

It would appear, then, that the new system is not only going to cause many problems but is likely to jeopardize the safety of the patients even more than is at present the case. Is it not likely to result in a certain number of overtime hours being designated as the limit in each hospital in order that those in training will not be asked to work for too long?

Would it therefore not have seemed wiser to increase salaries, particularly those of the Ward Sisters, without decreasing the number of hours to be worked each week or paying overtime money? Would we not rather be treated as professional people knowing that we work as is necessary, and be paid a salary in accordance with the responsibility undertaken? In addition, is this not likely to drive more nurses to the Agencies in view of the fact that their overtime payments are approximately 75 per cent greater?

Surely this is the wrong pathway? The profession should concentrate on treating its members in the correct manner, instead of offering them carrots which are calculated to worsen an already grave situation.

OBITUARY

Dr. Herzl Kaufman

Herzl Kaufman came to Guy's for postgraduate training in Psychiatry after originally qualfying from University College Hospital, and having achieved the additional distinction of graduating with an Honours Degree in Philosophy from the University of London. He had served in the R.A.M.C. in the Second World War with the rank of Major. After a memorable and mutually most enjoyable stay with us here, he became a specialist in Psychotherapy and retained a warm and lively connection with Guy's, which remained unbroken until his sudden and tragic death on 16th October.

What everyone who knew him well will cherish most fondly in their recollections of him were his utter dependability and unremitting concern for his patients, whom he treated not only with exemplary skill but with rare kindness and perceptive wisdom; and above all his enchanting sense of humour. This latter quality endeared him to patients and colleagues alike: and both were proud to know him as their friend.

He was a dedicated and highly professional physician, with a vision and insight which illuminated his compassion for others; although he would never spare or pity himself. He had that very special gift of seeing the funny side of tragedy, as well as the tragic aspects of what might otherwise have seemed funny or even ludicrous. He will long be mourned by all who knew him; for he bravely shouldered the burdens of very many of his fellow men and women. But his gentle laughter lit up our lives, and that, I think. is how he himself would wish to live on in our memories—as indeed he will.

D. STAFFORD-CLARK.

NOTICES

Guy's Society for Social Responsibility in Science

Announce two meetings :—

Thursday, 25th November, 5.30 p.m., in the Dental Lecture Theatre. "How will human society apply an understanding of the 'Human Brain'? The Dreams and Doubts of a Brain Research Worker."

Dr. Alan Boyne, Department of Biochemistry, University of Cambridge.

Thursday, 2nd December, 5.30 p.m., in the Physiology Lecture Theatre. "Madness and Morals."

Dr. Morton Schutzmann, Chairman of the Arbours Association, which aims to stop those under emotional stress being treated as mentally ill.

GUY'S HOSPITAL SWIMMING CLUB ANNUAL GALA

will be held at the **WHITECHAPEL BATHS,** Goulston Street, E.1., on **Wednesday, 24th November** from 6.30 to 8.30 p.m.

All swimmers and spectators welcome. Admission free.

Mr. J. H. Hanby, O.B.E. F.Ch.S.

A memorial service is to be held in Guy's Hospital Chapel, London, S.E.1., on Thursday, 2nd December, at 12 noon.

BOOK REVIEW

UROLOGY AND RENAL MEDICINE, by J. E. Newsam and J. B. B. Petrie. Livingstone 1971. 259 pages. Price £1.25.

Urology is a subject which is dealt with badly in General Surgical textbooks for students and there is a great need for a book such as this. I can only think of one other textbook which is suitable for students, that is "Chapman's Outlines of Urology."

"Urology and Renal Medicine" is written by a Surgeon and a Physician, and by combining Nephrology and Urology it avoids confusion and overlap. The text is clear, concise and complete. Of necessity it is dogmatic and therefore perhaps a little dull. On the other hand, at the end of each chapter there are good references for further reading. There are some minor deficiencies which are perhaps a matter of opinion, for example, analgesic nephropathy is dealt with in very little detail and also the effects of uraemia in drug excretion is scantily described. This is a subject which is often handled badly by Physicians.

There are, of course, some matters of opinion which Urologists will differ over, but in a book this size this cannot be helped. Perhaps there is a lack of balance here and there, for instance, there are four pages on the development of the urinary tract which are excellent in themselves, but perhaps unnecessarily long compared with two pages on carcinoma of the bladder.

The book is mainly written for undergraduates, but it would also be useful for postgraduates taking the Fellowship and nurses caring for patients with medical and surgical disease of the kidneys.

I am sure this is a book that every student should read and preferably should buy and keep. C.H.K.

Students' Medical Education Committee

Contrary to popular belief, the Medical Education Committee is not:— (a) defunct, (b) a figment of the imagination, (c) a toothless, emasculated body which sits and talks behind closed doors, (d) an outlet for the megalomaniac tendencies of some individuals in the student body.

What it is, in fact, is a group of elected representatives from you, the medical students; it meets to talk about possible changes in the curriculum and to pass recommendations on to the appropriate authorities. Most of the changes which have recently taken place in the arrangement of the curriculum have come about through the efforts of this committee.

The important point is that the individuals on the Committee are your representatives and, as such, have no right to act on their own behalf. Unfortunately, however, like the members of most democratically elected bodies they soon lose contact with the views of the electorate and begin to act in a more or less autonomous fashion. To counteract this, you, as individual students, should get to know your representatives and make sure that they are aware of your point of view over curriculum matters. If you have any constructive criticism about your course and the way it is run, the most effective way to air your view is to tell your Medical Education Committee representative.

The representatives are:—

For 2nd M.B. students—J. E. M. Fox, Tim Goulder, Rudy Bilous, and Andy Dawson.

1st year clinical—Mike Levene, and Jim Richardson.

2nd year clinical—Philippa Birch, Paul Hewish, and Rhys Williams.

3rd year clinical—Nick Bateman, and Richard Darling.

Elections for a 1st M.B. candidate will take place shortly.

R.W.

CORRESPONDENCE

The Ward Sister

SIR,—Doctor and Mrs. Kilby (6th November) have exposed the lack of insight and injustice of our organisers. The National Health Service was conceived for the benefit of the patient but Parkinson's Law has taken over.

Most of us learnt much from Sisters who had spent many years in the wards and maybe the quality of nursing was better when practical nusing was the vocation of a lifetime.

Someone who wants to nurse has a different ambition from somebody who wants to administer and it is unfair that in order to obtain full privileges they must bend to Salmon for worldly reward. We will in due course have so many administrators that there will be nobody for them to administer and what will the patient do then poor thing?

Yours faithfully,

DAVID ERSKINE.

Tanglewood, Kemnal Road,
Chislehurst, Kent.

The Rudge-Thomas Syndrome

SIR,—We would like to bring to your attention our increasing awareness of a hitherto unreported condition which we have repeatedly observed over the past few months. This illness, in our experience, has been confined to a highly select group of patients, the characteristics of which are:

(1) Young males.

(2) Invariably good looking.

(3) Of exceptional intelligence.

(4) Impending Final examinations.

The following features are suggestive of the illness:—

(1) Central abdominal pain, of a colicy nature.

(2) Diarrhoea.

(3) Frequency of micturition.

(4) Increased sweating.

(5) Mulligrubs.[1]

(6) Tremor.

(7) Insomnia.

The aetiology of this fascinating condition is as yet unknown.

Initial treatment of our group of patients has been mainly directed at psychotherapy, with desensitisation at our Queen's Square clinic. The simple phrase, "You have passed", often results in dramatic improvement.

With a due sense of modesty we would like to name this the Rudge-Thomas syndrome. We would be interested to hear from any others with experience of this condition, and any of their significant results.

Reference:

[1]Oxford English Dictionary.

Yours, etc.,

C. J. RUDGE.

C. J. THOMAS.

East Wing.

Ted Barrow

SIR,—It is with much regret that we have to announce the departure of Ted Barrow, the Students' Club Bar Steward. Ted has been with us for four years, during which time he has not only managed the bar most efficiently, but has created a convivial atmosphere, from which so many students, past and present, have benefited.

Those who were present prior to Ted's arrival will fully appreciate his contribution, and I'm sure all students would like to join myself and the bar committee in wishing Ted every success in his next employment.

Anyone wishing to show their appreciation of Ted's service should send their contribution to myself.

Yours, etc.,

TIM COX,

East Wing,
Guy's Hospital,
London, S.E.1.

Appeal For Clothes

SIR,—During the past two years the voluntary service scheme in Guy's has been called upon, on numerous occasions, to provide clothes for patients leaving the hospital either for convalescence, transfer to another hospital, or return to their own home.

There are many instances when, either because clothes are ruined as a result of an accident, or because they have had to be destroyed that we are called upon to re-equip a person for return to everyday life. During recent months the demand has been very heavy, and our stocks are very low indeed, and we must appeal for further supplies or else the service will grind to a halt.

Would you please allow me to ask, through the *Gazette*, for discarded clothing of any kind. We have a particularly heavy demand for men's clothing—not forgetting underclothes and shoes, but from time to time we have been asked to produce every size and type of garment in existence.

Please turn out wardrobes and send any clean clothing and shoes you no longer requires to me, care of Guy's Hospital. I assure you they will be used to great advantage.

Yours sincerely,

MARIE MCGLONE,
Organiser of Voluntary Service.

Guy's Hospital,
London, S.E.1.

SPORT

Very rarely are all the players from the best Guy's side at any sport put out all at once except in Cup matches. The lower teams usually have to be cajoled, bribed or bullied into playing and then give up for several weeks. This article is an attempt to find some reasons for this state of affairs.

Any student arriving at Guy's has immediately and almost forcefully impressed on him the phenomenal number of activities in which he may partake. Everyone hopes the freshers' tea party this year will be shorter than it was last year, but there are always new clubs to hear from (and the bar has been open for some time already). A few students may get interested in something that they never had a chance to do before, especially if the tiddly-winks club speaks longer and louder than the soccer club. (It has been observed that the most effective speakers are the ones who resist the temptation to speak.)

However, the state of decline of the major winter clubs is only partly due to widening interests. Formerly even the fourth team were a reliable side who would turn out to ensure that their teammates were not let down. Now it is commonplace to cry off on Thursday night or to play only every third weekend, whilst the others in the side keep it going of course.

Not only are the students unreliable but now, having persuaded the best players to get fit for Guy's they may easily trot off to another, usually "better" club. They do this in order to raise their game and get "noticed" and Guy's is used as a springboard to higher things.

The way to recover from this state of affairs is to overcome the apathy and concentrate on reliability, so that being a regular player is not merely a weekly keep-fit chore but also an entertaining afternoon.

RUGBY

2nd XV v. SIDCUP 'A'

Lost 16—24.

The second XV suffered their second defeat of the season, but one cannot detract from their fine performance. Although robbed of two of their bigger and more experienced players, due to matters beyond their control, they put up a tremendous fight against a bigger and better organised team.

Playing with the slope and with the sun in their opponents eyes, Guy's started promisingly. Unfortunately on Sidcup's first arrival in Guy's territory, Guy's suffered the first of a series of strange refereeing decisions, and Sidcup scored from the penalty. Almost immediately Sidcup returned to the Guy's 25, and from a line-out the Sidcup scrum-half managed to wriggle over the line, after some slack marking. From then on it was all Guy's. They scored a fine try when D. Jones made a break, and the ball was quickly transferred to A. Portelly on the wing, who ran in the try. Rick Fitton then kicked a fine penalty to bring the scores level. In their first constructive move of the match Sidcup scored a try. R. Fitton then added another penalty for Guy's. So at halft-time Guy's trailed 9—11.

Sidcup played sensibly in the second half and used the slope advantage to the maximum. Guy's defended magnificently with some fine tackling from the back row and the backs. Gradually the big Sidcup pack tired and superior fitness saw Guy's get gradually on top. Unfortunately while Guy's were in a strong attacking position, a Sidcup player latched on to a wild pass and scored near the posts. This was a sickening blow, then another penalty to Sidcup under the posts saw them further into the lead. Undaunted Guy's played the final fifteen minutes entrenched in Sidcup territory. They were rewarded by a fine try by A. Portelly who showed a fine turn of speed to score his second try, and in his first match for the second XV showed great promise, Rick Fitton converted the try and Guy's went down gallant losers 16—24.

It is hoped that sometime during the season the 2nd XV will be able to field the teams originally selected, then I am sure the team will be very successfull.

Team: R. Fitton, A. Portelly, R. Yetton, J. Rees, J. Shutes, D. Jones, D. Merrett, G. Marcus, J. Forbes, R. Burlinson, S. Challacombe, J. Fewster, P. Reesbeck, H. Holliday, M. Portelly.

SOCCER

1st XI v. BART'S

Guy's 4 Bart's 0.

A cold, clear afternoon on the bumpy pitch at Chislehurst saw Guy's line up against opposition with a high pre-match reputation. Guy's attacked from the start, but twenty minutes of dominance passed before Winter controlled a pass from Lindridge which was hard enough to be mistaken for a shot, and the Bart's 'keeper was given no chance. Defensively, Guy's had all the answers to quick attacks by the Bart's forwards and half-time saw us grumbling about the missed opportunities, Barker having narrowly missed and hit the woodwork and Drage having had several solo efforts thwarted by the goalkeeper. Walker was getting colder.

The second half saw a similar pattern emerge with Guy's winning possession but bunching too much and not calling enough to effectively use it. An uncharacteristic lack of selfishness developed amongst the forwards who insisted on passing the ball to and fro on the edge of the penalty box until the opposition could get in a tackle. Goodman took his usual rest to fix his contact lenses and Winter rounded off one of the many good moves by actually scoring from close range. Inspired by this, Drage ran with the ball from well inside his own half, round the entire Bart's team at a genuinely high speed, only to fail to beat the goalkeeper from four yards. This ultimate denial was psychologically too much for him and it was left to the defence to console the forward line with two fine goals. Goodman appeared from nowhere to forcefully turn a centre from Barker past the 'keeper and Lindridge decided to take a short route through the packed defence, finally nudging the ball inside the right-hand post. The yo-yo performance level of the team was on an upswing, but there is no truth in the rumour that Barker was paid not to play.

Team: T. Walker, N. Harradine, A. Goodman, D. Lindridge, J. Edwards, M. Winter, P. Coley, S. Drage, J. Ramsey, J. Vlitos, G. Barker.

SWIMMING

The Swimming Club is delighted to announce that the Annual Club Gala will be held on the 24th November at the Whitechapel Baths from 6.30 to 8.30 p.m. The Whitechapel Baths are within easy access of the Hospital, either by underground to Aldgate or by bus (No. 10) from London Bridge. Events include freestyle, breaststroke, backstroke and butterfly races and various relays. Obstacle races, ingeniously planned will endeavour to make the evening a memorable one. Water polo matches of a mixed variety will be staged! All swimmers, pseudo-swimmers and spectators will be very welcome. All those interested should give their names to one of the following: (i) Theresa Dwyer (Nurse's representative); (ii) Frances Abels (dental student); or (iii) Rod Bowering (Secretary).

WATER POLO

Water polo training sessions have now been rearranged and take place every Wednesday from 8—9 p.m. at the Whitechapel Baths, Goulston Street, E.1. We are also fortunate in being able to share the Mile End Baths with the London Hospital on Mondays from 6—7 p.m.

Guy's I consist of a few remaining first team originals with the addition of F. Cordingley and H. Cottrill. The other first team members are J. Clarke (Captain), T. Sands, C. Bevis, G. Newman and R. Bowering.

Guy's II consists mostly of freshers, a number of whom have shown keen interest and the following have represented Guy's II in one or more of the matches played at St. Mary's so far: N. Campbell, W. Crozier, G. Auckland, E. Gavin, N. Mooters, N. Nicholas, J. Leach, C. Holden, R. Vivian and J. Murphy.

GUY'S II v. ST. THOMAS'

Lost 6—0.

Guy's played quite well but unfortunately the speed of the opposition and much "breaking loose" at close marking brought Guy's defeat. On several occasions shots at goal were marginally missed. Campbell played in goal for the first half and with Nicholas taking up the position in the second half, between them made some good saves. Gavin moved very fast in the water and was a great asset to the team. More overall ball handling practice should improve the team considerably. Much practice is needed especially in playing together as a team and in the marking of the opposing players.

GUY'S II v. ST. MARY'S III

Tuesday, 9th November, Lost 5—3.

Guy's were in good spirits for this match especially when Rowlands turned up at St. Mary's to complete the team. The opposition won the toss and Guy's defended the shallow end for the first half. Within a couple of minutes, Holden playing forward scored the first goal of the match, St. Mary's men scored a quick succession of three goals which put them in the lead at half time. Amidst much furore and dubious refereeing, Guy's banged home two goals almost one after the other, at the beginning of the second half. St. Mary's realising that we had now equalised with them appeared to be fighting harder. The combination of lucky "breaks" by the opposition and unfortunate shots at goal by Holden, Rowlands and Bowering enabled them to score the two winning goals— in spite of men from both sides being sent out. Vivian played well in midfield and Campbell made some fine saves in goal.

R.B.

HOSPITAL INFORMATION

THE BOARD OF GOVERNORS OF GUY'S HOSPITAL.

Applications are invited for the appointment of **Trainee Registrar** in the Department of Diagnostic Radiology with duties to commence as soon as possible until 30th September, 1972 in the first instance. Forms of application are obtainable from and should be returned to the Superintendent, Guy's Hospital, London, SE1 9RT, not later than **3rd December, 1971.**

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited for the Astley Cooper Studentship tenable at Guy's Hospital Medical School. The Student, who is the Astley Cooper Assistant to the Curator of the Gordon Museum, will be elected for a period of three years, the salary being approximately £340 per annum. Application should be made on a form obtainable from the Dean, Guy's Hospital Medical School, SE1 9RT.

HOUSE APPOINTMENTS

GUY'S HOSPITAL

December, 1st, 1971

House Physicians

Dr. Mann, Dr. Scott, Dr. Clark and Dr. Grahame — Miss D. C. T. Watson, 3 *months*, Mr. R. J. Hay, 6 *months*

Dr. Hardwick, Professor Trounce, Dr. Cameron, and Dr. Ogg — Mr. J. D. Mackay, 3 *months*, Mr. B. V. Martindale, 6 *months*

Dr. Houston, Dr. Knight, Dr. Deucher, and Dr. Grimble — Mr. H. J. Klass, 3 *months*, Mr. A. J. Camm, 6 *months*

Professor Lessof, Dr. Joiner, Dr. Burry and Dr. Sowton — Mr. W. F. Jackson, 3 *months*, Mr. A. M. Ross, 6 *months*

House Surgeons

Professor I. McColl — Mr. J. G. Williams, 3 *months*

Mr. Blackburn and Dr. Wayte — Mr. T. Higenbotttam, 3 *months*

Mr. Lawrie — Miss M. J. Van Essen, 6 *months*

Mr Glover and Mr. McArthur — Mr. J. D. Wrout, 3 *months*

Mr. Beard — Mr. D. W. Gorst, 3 *months*

Mr. Maynard and Dr. Wayte — Mrs. L. Light, 6 *months*

Mr. Ellis — Mr. J. R. Pepper, 3 *months*

Mr. O'Flynn and Mr McArthur — Mr. G. M. A. Heaton, 6 *months*

House Surgeon to the Breast and Plastic Surgery Units

Mr. R. G. Jezzard
3 *months*

Gynaecological House Surgeons

Mr. P. G. Jackson
3 *months*
Mr. R. G. Thomson
6 *months*

Throat and Ear House Surgeons

Miss S. M. Brown
3 *months*
Mr. A. Scoufield
6 *months*

Orthopaedic House Surgeons

Mr. D. A Raper
3 *months*
Mr. D. R. Jones
3 *months*
Mr. J. A. Morgan
6 *months*
Mr. E. G. Latimer-Sayer
6 *months*

Each Orthopaedic House Surgeon will spend 6 weeks at New Cross Hospital.

S.H.O. to the Renal and Transplant Units

Mr. A. J. Rees
3 *months*

Genito-Urinary House Surgeons

Mr. J. S. N. Anderson
3 *months*
Mr. P. R. Harrison
6 *months*

Children's House Physicians

Mr. B. Dick
3 *months*
Miss R. J. Thorburn
6 *months*

Causualty Officers

Mr. D. A. Jones
3 *months*
Mr. P. H. Reinhold
3 *months*
Mr. M. E. Taylor-Pearce
3 *months*
Mr. D. G. Healey
6 *months*
Mr. D. A. Rosenberg
6 *months*
Mr. N. Coe
6 *months*

Resident Obstetricians

Mr. S. A. Aldmodhzar
3 *months*
Readvertised
6 *months*

Neurological House Physician

Mr. C. R. A. Clarke
3 *months*

Dermatological House Physician

Mr. R. J. Rycroft
6 *months*

House Physician in Child Psychiatry

Readvertised
6 *months*

House Surgeons to the Thoracic Unit

Mr. J. E. Dussek
3 *months*
Mr. R. J. Wainwright
6 *months*

House Physicians in the Department of Psychological Medicine

Mr. M. H. Mubbasher
Mr. M. Redfern
Mr. M. Seear

Resident Anaesthetists

Mr. J. R. Wedley
3 *months*
Mr. G. S. MacMillan
3 *months*
Mr. J. A. R. Pook
6 *months*
Miss A. M. Tihanyi
6 *months*

Senior House Officers to Nuffield House
Mr. M. G. Sutton
3 *months*
Mr. A. J. West
6 *months*

Children's House Physicians at Evelina Hospital

Miss S. E. Read	1. 8.71—31.1.72
Mr. S. Kraemer	1.10.71—31.3.72
Mr. H. M. Wieselberg	1.12.72—31.5.72
Miss C. A. Chalmers	1. 2.72—31.7.72

Casualty Officers at Evelina Hospital
Mrs. S. Lena
3 *months*
—
6 *months*

ST. OLAVE'S HOSPITAL

House Physicians:
Mrs. C. G. Bissenden
3 *months*
Mrs. F. E. Jones
6 *months*
House Surgeon:
Miss M. L. Cann
6 *months*
Senior House Surgeon:
Mr. P. Toone
6 *months*
Gynaecological House Surgeon:
Mrs. A. Bhoomkar
3 *months*
S.H.O. in Psychiatry:
Mr. S. D. Joshua
3 *months*

NEW CROSS HOSPITAL

House Physician in General Medicine and Geriatrics:
Mr. J. S. Polkinhorn
3 *months*
Mr. A. B. Murgatroyd
3 *months*
Medicine and Geriatrics:
Mr. J. K. Mackenzie
6 *months*
Mr. R. H. Mackay
6 *months*

Orthopaedic House Surgeons:
See under Guy's

Senior House Officer to Rehabilitation Unit:
Mr. A. Bhoomkar
3 *months*

BECKENHAM HOSPITAL

House Physician:
Miss G. L. Hoare
3 *months*
House Surgeon:
Miss G. A. Redding
3 *months*

GREENWICH DISTRICT HOSPITAL

House Physician to Dr. Mallinson:
Mr. D. Macdiarmid
6 *months*
House Surgeon to Mr. O'Flynn, Mr. Wilson, Mr. Hollis and Mrs. Wengraf:
Miss A. Ironside
6 *months*
House Surgeon to Mr. Eldin and Mr. Cobb:
Mr. C. C. Baker
6 *months*

HITHER GREEN HOSPITAL

House Physicians in General Medicine and Infectious Diseases:
Mr. R. C. Fieldsend
3 *months*
Mr. A. R. Valentine
6 *months*

LEWISHAM HOSPITAL

House Physician to Dr. Price:
Mr. P. W. L. Ribet
6 *months*
House Surgeon to Mr. Lynn Evans:
Mr. R. G. A. Behrman
6 *months*
House Physician to Dr. Roberts:
Mr. S. D. Horseley
6 *months*
House Surgeon to Mr. Ivo-Smith:
Mr. K. Thompson
6 *months*
House Surgeon to Mr. France, Mr. Bingold and Mr. Monty:
Mr. T. de F. Mendis
6 *months*
House Surgeon to Mr. Le Brun:
Mr. J. D. Wheal
3 *months*
House Physician to Dr. Llewellyn Smith:
Mrs. L. J. Rockall
3 *months*
House Surgeon to Mr. Cavendish:
Miss P. L. Pantin
3 *months*

MILLER HOSPITAL

House Physicians to Mr. Hartley and Dr. Bassadone:
Mr. M. A. Mansell
3 *months*
Mr. N. A. G. Jones
6 *months*
(S.H.O.) Mr. J. D. Martin
3 *months*
House Surgeon to Mr. Candy and Mr. Gwynne Evans:
—
3 *months*
House Surgeon to Mr. Eldin:
Mr. J. R. M. Ross
3 *months*

ORPINGTON HOSPITAL

House Surgeon with Dental:
—
6 *months*
House Surgeon with E.N.T.:
—
6 *months*
House Surgeon with Orthopaedics to Mr. Boxall and Mr. Lam:
Mr. C. J. Bennett
6 *months*
House Surgeon with Gynaecology:
Mr. A. J. Shellim
6 *months*
House Surgeon to Mr. Walker-Brash and Mr. Lam:
—
6 *months*

PEMBURY HOSPITAL

House Surgeon to Mr. Gibson and Mr. Lavy:
Mrs. A. M. de Carteret
3 *months*
Mr. P. Matthews
6 *months*
House Physicians to Dr. Miller and Dr. King:
Mr. J. L. Bates
3 *months*
Mr. S. R. D. Coles
6 *months*

ST. HELEN'S, HASTINGS

House Physicians:
Mr. J. A. Dalziel
3 *months*
Mr. G. C. Taylor
6 *months*

ST. NICHOLAS, PLUMSTEAD

House Physician to Dr. Scott:
Mr. G. Peters
6 *months*

P. J. HELLIWELL,
Superintendent.

JUNIOR STAFF COMMITTEE

The following representatives have been elected to serve on the Junior Staff Committee for 1971-72.

Medical Registrars
I. A. Baker
C. I. Roberts

Surgical Registrar
N. J. Barwell

Registrar from the Medical Specialties
J. G. Pickering

Registrar from the Surgical Specialties
F. A. W. Schweitzer

Registrar in Radiology
R. Gilkes

Registrar in Pathology
R. M. Ibbotson

Registrar in Psychiatry
Ruth Seifert

Lecturers (all grades) in Medical School Departments
T. M. Coltart
B. H. Hicks
B. V. Robinson
E. C. Tatchell
R. O. Weller

ROYAL COLLEGE OF SURGEONS OF ENGLAND

F.F.A.

October, 1971

M. J. Lindop — J. H. Williams

UNIVERSITY OF LONDON

Doctor of Philosophy (Ph.D.)

September, 1971
N. S. Track (Biochemistry)

Doctor of Medicine (M.D.)

September, 1971
J. R. Audy

Master of Surgery (M.S.)

September, 1971
J. G. Sekabunga

EXAMINING BOARD IN ENGLAND

Final L.R.C.P., M.R.C.S.

October, 1971

Pathology

R. M. Barry	M. L. Nancekievill
A. E. A. Ford Jones	N. R. Pinder
D. M Frost	D R. Richardson
D. M. Gillman	A. M. Royston
L. K. Hampson	P. J. E. Smyth
G. James	M. S. Sorefan
A. M. Light	I. D. S. B. Starke
H. U. S. McMichen	K O. Thompson
	V. J. Wass

Midwifery

R. M. Barry	A. M. Royston
N. C. Bartlett	P. J. Skinner
C. J. Bennett	M S. Sorefan
J. R. H. Leader	K. O. Thompson
H U. S. McMichen	R. G. Thomson
N R. Pinder	S. C. Wells

Surgery

N. J. Astbury	N. C. H. McNeil
N. C. Bartlett	D. A. Neville
A. J. G. Batch	H. M. Powell
C J. Bennett	A. J. Prisk
R. M. Darling	S. C. Rankin
G. C. Dunbar	D. R. Richardson
R. M. Ede	M A. J. Rosenberg
S. J. Golding	M. M. Shaw
I. D. Harrison	J. C. B. Shutes
J. L. Hewlett	P. J. Skinner
C. J. Lamb	P J. E. Smyth
D. A. F. Lee	M. A. Stodell
A. M. Light	S. C. Wells
A. Little	V. J. Wass
C. J. F. Manning	N. O. Yerbury

Medicine

N. K. Barber	L. K. Hampson
N. C. Bartlett	G. James
D. N. Bateman	L. L. Judd
N. D. S. Bax	N. J. Marks
C. J. Bennett	M. Munir-Ahmed
D. A. G. Cook	M. L. Nancekievill
M. T. Fenner	G. R. Pietroni
A. E. A. Ford Jones	E. M. Reuben
D. M. Frost	C. J. Rudge
A. M. Garons Williams	R K. Stacey
P. C. Gartell	I. D. S. B. Starke
R. A. G. Goodhart	C. J. Thomas

PERSONAL

FOUR GUY'S NURSES urgently require furnished flat in vicinity of Guy's. Doctor/father will guarantee rent. Bulleid, Austrey Wood, Rownhams, Southampton.

CHANGES OF ADDRESS

Peter and Kathrin Bowen-Simkins have moved to 37, Heath Drive, London, S.W.20. Tel: 01-542 8171.

As from 7th February, 1972: Lieut. Elizabeth M. Howard, Q.A.R.A.N.C., Officers' Mess, British Military Hospital, King's Park, Kowloon, Hong Kong. BFPO 1.

Abe Miller, L.R.C.P., M.R.C.S., D.P.H., 502, Seven Oaks, Johannesburg, South Africa.

Dr. and Mrs. B. J. Rowlands, 8a Little Norton Lane, Sheffield. S8 8GA, Yorkshire. Tel: 758393.

BIRTH

SOUL—On 3rd October, 1971 to Anne (née Goodhart) and John Soul, a son, Nicholas John.

VERNON—To Barbara (née Brice) and David Vernon, on 25th October, a daughter, Catherine Mary Anne, a sister for Richard.

MARRIAGE

ROWLANDS—THOMAS—Dr. Brian Rowlands to Miss Judith Thomas at Loughor, South Wales on 16th October, 1971.

DEATH

MUIRHEAD—On 26th October, suddenly, at his home Bathfield House, Ashover, Derbyshire, H. C. Muirhead, ophthalmic surgeon, formerly of the Royal Hospital, Chesterfield.

NEW STUDENTS

1st M.B. STUDENTS

October, 1971

Brown, Neville P. R.	Henry Hartland Grammar School, Worksop.
Bundock, Andrew D.	Cambridgeshire High School for Boys.
Franklin, Suzette L.	Norwood Technical College.
Gay, John C. C.	Brockenhurst College, Hampshire.
Godsland, Judith M.	Wimbledon County Grammar School for Girls.
Harrison, Christopher M.	Ampleforth College.
Kahane, Gillian M.	Charlton Park College, Cheltenham.
Koo Seen Lin, Lindsey C.	Royal College, Port Louis
Long, Margaret R.	Portsmouth High School
McLauchlan, Christopher A. J.	Ipswich School.
Pike, Michael G.	St. Edmund Hall, Oxford.
Tootell, Sandra A.	Ravensbourne School for Girls, Bromley.

2nd M.B. STUDENTS

October, 1971

Allen, Kathryn E.	Cheltenham Ladies College.
Arab, Mahmoud	Bath Technical College.
Auckland, Geoffrey D.	John Ruskin Grammar School.
Bardsley, Nigel D.	City of London Freeman's School.
Barker, Susan G.	Wycombe Abbey School.
Baylis, Timothy M.	Colchester Royal Grammar School.
Bell, Thomas R. D.	Duke's Grammar School. Northumberland.
Bigwood, Neil	Barking Abbey Comprehensive.
Bourne, Michael G. N.	Queen Mary's Grammar School, Walsall.
Brander, Jane C.	Weald of Kent School for Girls, Tonbridge.
Brear, Steven G.	Normanton Grammar School, Yorkshire.
Broughton, Louise A.	Havant Grammar School.
Campbell, Neil J.	Oundle School.
Carnegie, Christina M. D.	Benenden School.
Clapham, Michael C. C.	Blundell's School.
Clarke, Stephen L.	Normanton Grammar School, Yorkshire.
Coates, David P.	Kingston Grammar School.
Cole, David J.	Downside School, Bath.
Cole, Hilary E.	Wimbledon High School S.W.19.
Collett, A.	Gunnersbury Catholic Grammar School, W.3
Cox, Barbara J.	Chiswick School.
Crowley, Theresa	St. Joseph's Roman Catholic Comprehensive, Port Talbot.
Crozier, William C.	Rutherford School, Newcastle.
Cunnington, Patricia H.	Convent of the Holy Ghost School, Bedford.
Dennison, James	Judd School, Tonbridge.
Domville, Ian E.	Blue Coat School, Liverpool.
Earnshaw, Peter H.	Batley Grammar School.
Ede, Roland J.	Hastings Grammar School.
Efthimiou, John	Holloway School, N.7.
Ferris, Mark B.	Hele's School, Exeter.
Fine, David R.	Brentwood School, Essex.
Fitzgerald Frazer, Jonathon S.	Epsom College.
Gaunt, Peter N.	Whitgift School, Croydon.
Gloyn, Philip R.	Varndean Grammar School, Brighton.
Goodship, Timothy H. J.	Hailbury College.
Griffiths, Anne E.	Cheltenham Ladies College.
Gross, Diana H.	Bromley High School.
Haiart, Dominique C.	Sevenoaks School.
Hammett, Alistair I.	City of London School.
Handler, Clive E.	Dulwich College.
Hannaford, Robert W	Christ College, Brecon.
Harris, Andrew R. B.	Radley College, Abingdon.
Holden, Colin A.	Prescot Grammar School.
Horton, Jeremy J.	Hemsworth High School.
Hughes, Christine	Clifton Hall Girls Grammar School, Nottingham.
Hughes, Gareth J.	Aberdare Boy's Grammar School.
James, Peter N. E.	Cardiff High School.
Jenkinson, Patricia M. A.	Wycombe Abbey School
Jones, Richard H.	Bishop Gore School, Swansea.
Jones, Roderick I.	Helsby County Grammar School for Boys.
Lau, Terry T. Y.	Woodhouse Grove Bradford.
McArthur, John D.	Downside School, Bath.
McNulty, John F.	St. Chad's College, Wolverhampton.
Marginson, John E.	Bolton School.
Martin, Clive M.	Enfield Grammar School.
Martin, Douglas G.	Poole Grammar School.
Martin, Ian R.	Frimley and Camberley County Grammar School.
Masters, Nigel J.	Epsom College.
Mayer, Anthony D.	Tonbridge School; Sussex University.
Moore, Richard H.	Whitchurch High School, Cardiff.
Murphy, Gerard	De la Salle College, Hove.
Nicholas, Nicolaou S.	William Ellis School, N.W.5.
Nicholas, Richard C.	Rugby School
Nicholson, Iain G.	Epsom College.
Overal, Susan G.	Chichester High School for Girls.
Parry, Rosemary L.	Cheltenham Ladies College.
Paterson, Jeremy R.	Mill Hill School, N.W.7.
Payne, Amanda	Channing School
Perkins, Rhys A. B.	Epsom College
Perkins, Ralph D.	Tiffin Grammar School.

Pillai, Chittaranjan N.	St. Thomas' College, Colombo, Ceylon.
Power, Sharon J.	Portsmouth Northern Grammar School for Girls.
Price, Delyth A.	Glanmor Senior Girls School.
Quyyumi, Arshed A.	West Hatch Technical High School.
Radia, Krishnakant	Norwood Technical College.
Reeves, Michael W.	Cranbrook School.
Rivett, James F.	Franlingham College.
Royle, Peter	Sale County Grammar School for Boys.
Salmon, John B.	Tonbridge School.
Scane, Robert G.	Portsmouth Grammar School.
Sharp, David R.	Sevenoaks School.
Sireling, Martin S.	Westminster City School.
Slocombe, Gareth W.	Collyers' School, Horsham.
Smith, Gillian M.	Malvern Girls College
Stewart, Alan C.	John Fisher School, Purley.
Thomas, Anne G.	Cwmtawe Comprehensive School, Pontardawe.
Thornton, Vyvian G.	Colfe's Grammar School.
Tidman, Michael J.	Collyers Grammar School, Horsham.
Timms, Philip W.	Brentwood School.
Trotter, Geoffrey G.	Bede School, Sunderland.
Trounce, John Q.	Bishops Stortford College.
Van de Pette, John E. W.	Hayes County Grammar School.
Vevers, Geoffrey W. G.	Shrewsbury School.
Volk, Heather M. J.	Wilmslow County Grammar School for Girls.
Walford, Geraldine A.	Notting Hill and Ealing High School.
West, Andrew	John Ruskin Grammar School.
Whitbread, Rhoderick P.	Judd School, Tonbridge.
Wilkinson, David	Arnold County High School.

1st B.D.S. STUDENTS

October, 1971

Bakewell, Tordis	Sarpsborg Grammar School, Norway.
Bernsten, Per	Sandifiord Gymnas Universite libre de Bruxelles.
Björnaas, Jostein	Levanger Gymnas, Norway.
Davies, Roger C.	Rydal School, Colwyn Bay.
Evans Robert P.	Swansea College of Further Education.
Gilhooly, Michael G.	King Edward VI School, Nuneaton.
Girdlestone, Judith M.	Bromley High School.
Gjaere, Turid J.	Askim Gymnas, Norway.
Grant, Sandra I.	Bournemouth College of Science and Technology.
Heron, Christine W.	The Mount School, York.
Hooper, Susan M.	Wadhurst College.
Kolberg, Asbjorn	Levanger Gymnas, Norway.
Listerud, Tore	Foss Gymnas, Oslo, Norway.
May, Christopher D.	Epsom College.
May, Timothy S.	Birkenhead Technical College.
Owen, John G.	Epsom College.
Pieniazek, Jan P.	Paddington Technical College.
Portelly, Anthony C.	Prior Park College, Bath.
Poulter, Roy	Quintin Kynaston School, N.W.8.
Praed, Eleanor	Cirencester School.
Sova, Clare M.	Newstead Wood School for Girls.
Taylor, Coryn P.	Tunbridge Wells County Grammar School for Girls.
Taylor, Stephen D. B.	Berkhamsted School.
Vlitos, John P.	Queen Elizabeth College.
Watkinson, Peter S.	Queen Elizabeth Grammar School, Wakefield.
Willetts, Gregory M.	Foley College of Further Education, Stourbridge.
Zaki, Graeme A.	Rydal School.

2nd B.D.S. STUDENTS

October, 1971

Abrahmsohn, Glenn M.	Quintin Kynastin School, N.W.8.
Almeida, Jose, V. O.	Walbrook College.
Baker, Janice	Sutton High School.
Beioley, Richard A.	Bishop Veseys Grammar School, Sutton Coldfield.
Bennetts, Park P.	Churcher's College, Petersfield.
Bunyard, Martin A. W.	Bristol Polytechnic.
Cambell, Christopher J.	St. Joseph's Academy, Blackheath.
Chia, Vincent	Alleyn's School.
Cranfield, Michael J.	Hitchin Boys Grammar School.
Crook, Cheralyn	Colston Girls School.
Davies, Huw T.	Bishop Gore Boys School, Swansea.
Edgar, Gerald R. W.	Sevenoaks School.
Fan, Shun Yan E.	Acton Technical College.
Fewster, John A.	Kings School, Canterbury.
Fisher, Nigel L.	Alleyn's School.
Forbes, John M.	Damelin College, Johannesburg.
Gair, Margaret H.	Queen's College.
Gentry, Malcolm R.	St. Benedicts School, Ealing.
Glazebrook, Richard	Salesian College, Chertsey.
Gledhill, Anne P.	Greenhead Grammar School, Keighley.
Grant, Christopher D.	Eastbourne College.
Hargreaves, Mark A.	Blackpool Grammar School.
Harker, John H.	Hove Grammar School for Boys.
Hedley, Brian	Grangefield Grammar School.
Hollinshead, Francis S. B.	Shrewsbury School.
Ireland, John D.	St. Edward's School, Oxford.
Jacobs, Laurence B.	Howardian High School, Cardiff.
Jones, Martin W.	Grove Park Boys Grammar School, Wrexham.
Jones, Nicholas S.	Epsom College.
Jones, Peter R.	Rushcliffe Boys School, Nottingham.
Jones, Robert W.	Maesydderwen County Comprehensive, Swansea.

Kaspar, John P.	Trinity School, Croydon.
Kingon, Angus M.	Mill Hill School.
Lakhani, Bipinchandra, V. D.	Norwich City College.
Leach, John C.	Eastbourne Grammar School.
Maw, Judith	Retford County High School for Girls.
Merali, Shiraz S. A.	Westcliff High School for Boys.
Nabarro, Jennifer	Francis Holland School.
Nurse, Robert W. R.	Barnet College of Further Education.
Omar, Ridwaan	University of Leeds.
Parham, Richard A.	Filton High School, Bristol.
Parsons, Kenneth	Frederick Gough Comprehensive School.
Pettifer, John A.	University of Aberdeen.
Rajarayan, Rajkumar	Harrow School.
Rhimes, Godffrey, H.	Royal Grammar School, Guildford.
Schnetler, Jeremy F. C.	St. Dunstan's College.
Shipway, Michael W. H.	Cheltenham College.
Skipper, Anne J.	Worthing Technical High School.
Smith, Alistair J. S.	Thomas Peacocke School, Rye.
Smith, Philip B.	Archbishop Holgates Grammar School, York.
Steel, Richard J. H.	Wyggeston Boys School, Leicester.
Sykes, David G.	Bedford School.
Terry, Regan	Newstead Wood School, Orpington.
Trickett, Alison C.	Benenden School.
Vivian, Richard S.	Ellesmere College.
Wade, John T.	Rickmansworth Grammar School.
Wilkins, Menna	Llandeilo County Secondary School.
Wills, Martin A. J.	St. Alban's School.
Woodward, Robert C.	Oswestry School.

2nd M.B. COMBINED STUDENTS

Mackenzie, Ian J.	Mill Hill School: Guy's Dental School.

CLINICAL COURSE STUDENTS

April, 1971

Odgers, Robin C. B.	Rugby School. New College, Oxford.
Orr, Barbara M.	Malvern Girls College. St. Anne's College, Oxford.
Whitehouse, Andrew B.	Ellesmere College. Trinity College, Cambridge.

CLINICAL COURSE STUDENTS

October, 1971

Armstrong, Raymond D.	Royal School, Dungannon. St. John's College, Cambridge.
Brown, David J	Perse School, Cambridge. Queen's College, Cambridge.
Bullock, Keith N.	Merchant Taylor's School, Liverpool. Selwyn College, Cambridge.
Caffrey, Elizabeth A.	The Grammar School, Gateshead. Newnham College, Cambridge.
Cook, Alistair J.	King's College School, Wimbledon. Pembroke College, Cambridge.
Culliford, Larry D.	Cranleigh School, Surrey. St. Catherine's College, Cambridge.
Dick, Moira C.	Roseberry Grammar School, Epsom. Newnham College, Cambridge.
Forber, Robert K. J.	Canford School, Wimborne, Dorset. Trinity Hall, Cambridge.
Kettle, Paul R.	Malvern College. St. John's College, Cambridge.
King, Roger G.	Hymers College, Hull. King's College, Cambridge.
Lloyd, David H. O.	Westminster School. Gonville and Caius College, Cambridge.
McClure, Guy M. G.	Gordonstoun School. Exeter College, Oxford
Mann, Robert J.	Perse School, Cambridge. Corpus Christi College, Cambridge.
Momen, Moojan	Queen's College, Taunton. St. John's College, Cambridge.
Odom, Nicholas J.	Shrewsbury School. St. John's College, Cambridge.
Plowman, Piers N.	Seaford College. Emmanuel College, Cambridge.
Prior, John G.	Wintringham Grammar School, Grimsby. Selwyn College, Cambridge.
Reasbeck, Philip G.	King Edwards School, Birmingham. Gonville and Caius College, Cambridge.
Scott, David J.	Tiffin School, Kingston. St. Catherine's College, Cambridge.
Willicombe, Peter R.	Cardiff High School. Gonville and Caius College, Cambridge.
Wright, John G. C.	Radley College. Christ's College, Cambridge.

GUY'S HOSPITAL GAZETTE

EDITORS A. M. TURNER and J. L. LEWIS
NEWS EDITORS C. G. CHINERY and D. I. F. KELLEHER
SPORTS CORRESPONDENT R. W. BURNS
NURSING CORRESPONDENT Miss P. M. JEFFERIES
BUSINESS MANAGER Mrs. J. PATTERSON

FORTNIGHTLY TWELVE PENCE VOLUME 85 NUMBER 2176

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

D.E.S. and the Student Unions

The Department of Education and Science has landed its bombshell and the financing of Student Unions is to be reformed. The purpose of the proposed changes, according to the Consultative Document, is to regulate the level of union subscriptions, to place more control over the spending of union funds, and to make union membership optional. Perhaps a main motive for the changes is to curb political activities as these are "purposes which would more appropriately be supported by voluntary subscriptions". Unfortunately, virtually all sporting, social and cultural activities are covered by this phrase.

It is interesting that the purpose of the reforms seems to have changed since the inquiry was started. In 1970 its aims were to set a minimum standard for student unions in all spheres of higher education and to minimise the differences in union subscriptions. Instead, the present proposals will merely fragment unions and place greater restriction on their source of income.

In spite of the bad public image of some student unions, they are an essential part of university life. They serve a multitude of functions, most of which are neither political nor extravagant. Many unions are responsible for catering facilities, maintenance of common rooms, running student bars and they provide a community life at universities. Clubs within student unions provide opportunities for sport and for social and cultural activities which give an extra dimension to a university education. Unions also provide a means of representing the views of their members both on and off the campus.

There is little doubt that student unions are an essential part of university life. However, since the Government spends £3 millions annually on union fees, it does not want the money abused. There is considerable talk about "public funds" being spent by unions for political purposes. Once given to a union the money is no longer

"public" and it can be spent according to its constitution which defines the aims and activities of the union. It is approved by the university or college authorities and is legally binding. There is at present, therefore, a means of adequately controlling union activities.

Certain students have captured the attention of the media and the proposed reforms have been erroneously believed to be a much-needed clamp on student radicals. It is unfortunate that this image of "student revolution" exists because it does not involve the majority of students or their unions. It is also sad that in spite of universal condemnation of the proposals by radicals and reactionaries, students and dons, the general public does not know about the beneficial aspect of unions which will be lost. Large protests do not seem to gain public sympathy.

The proposals which the D.E.S. is contemplating show a complete lack of understanding of student unions and their faults. The reforms are out of all proportion to the defects. The saving to the Government would not be great and the administrative machinery involved would be agonisingly complex.

Kind Nature's Signal for Retreat

It has been quoted of David Hume that he was no more uneasy to think that he *would not be* after he died than that he *had not been* in any way before he was conceived. Not many of us share such equanimity about death, and not many of us are proficient at helping others to deal with their deaths.

It has become a commonplace to remark that doctors are fulfilling nowadays the role that the priest filled in former years; that doctors are listened to more than the church. How soon it will be before people go to war on the pretext of a schism of medical opinion, say about the controversy of acupuncture, is, however, less than clear. Nevertheless, as with most commonplaces, the observation has an element of truth. People who choose to believe in an after-life may be unable to accept the consolation of a last blessing from the church before they die. If a doctor is in attendance in such a situation the management of his patient is of extreme importance, more so than ever before. An understanding of others' attitudes to death is mandatory now that doctors are potentially able much more to control the timing of death, whether or not to delay it. It is also important in the rarer but quite as difficult situation when a doctor is asked by his patient to hasten death by giving him a lethal dose of drug. A doctor has to be well informed and confident before he can make any decision on those matters.

Senior members of the profession are experienced in talking with patients who are soon to die, and their relatives. Young doctors have no experience of this and practically no advice from their seniors while they are clinical students. In the last edition of the *Gazette* an article by Dr. Pembrey discussed a more scientific understanding of the experience of death. This week Dr. Brewer considers the effects on the individual of cancer, and also the fear of contracting

the disease and the general ill-informed belief that if people have cancer there is nothing to be done for them.

It should be debated by doctors whether people who are about to die should be encouraged to feel beatitude in the thought that they may not be in the world next morning; or whether we should approach life with the gratitude that death has not yet supervened. At present it would seem from the amount of doctors' training devoted to care of the dying that those are delusions that do not convince or console even the most optimistic of us and the honest approach to death is one of fear; that the best approach is not to think about it since it occupies so little of our time in life and it is best not to indulge those fears.

Professor of Surgery

After the announcement of the retiral of Professor Sir Hedley Atkins, Guy's men who are out of direct contact with the hospital and have not yet heard of his successor will be pleased to learn that Ian McColl, M.S., F.R.C.S., has been appointed as Professor of Surgery in the University of London and Director of the Surgical Unit. He has returned to Guy's after a period as Reader in Surgery and Surgeon to St. Bartholomew's Hospital, where he later became Sub-Dean to their Medical College.

GUY'S DIARY

DECEMBER

6	M	1.00 Clinical Lecture. Mr. RENDALL. "Varicose Veins."
		5.30 The Scientific Basis of Medicine.* Dr. V. P. WHITTAKER. "The Storage of Acetylcholine in Presynaptic Nerve Terminals."
7	Tu	1.00 Clinical Lecture. Mr. DOUEK. "The Sense of Smell."
		5.00 Clinical Medicine.* Dr. J. T. SILVERSTONE. "Psychiatric Emergencies."
		6.00 Update.* Dr. LAWSON McDONALD and Mr. DONALD ROSS.
9	Th	1.00 Clinical Lecture. Dr. JOINER. "Hypertension II."
10	F	2.15 Combined Round. Dr. STAFFORD-CLARK. "We'll all swing together."
14	Tu	1.00 Clinical Lecture. Mr. FLANNERY. "Neurogenic Bladder."
16	Th	1.00 Clinical Lecture. Dr. DEUCHAR. "Congenital Heart Disease."
17	F	1.00 Clinical Lecture. Dr. CLARK. "Intensive Care."

Dr. Stafford-Clark's is the last Combined Round of this Session.

*Denotes that the lectures will be televised and shown in the Anatomy Lecture Theatre.

NEWS IN BRIEF

Government Proposals to Reform the Financing of Student Unions

On 3rd November, the Department of Education and Science published a consultative document on the financing of Student Unions. Since that date there have been, and will continue to be student protests against the proposals. The Committee of Vice-Chancellors and Principals has also come out against the proposals.

Student Unions are at present financed by a compulsory levy from the Local Education Authority of each student. Where the student is awarded a minimum grant, or has no grant, the subscription is added to the student's fees. At Guy's the subscription for each student is twelve guineas. The money from the subscriptions totals £11,600, and is distributed by the Clubs Union Council to all of the clubs, societies and constituent organisations.

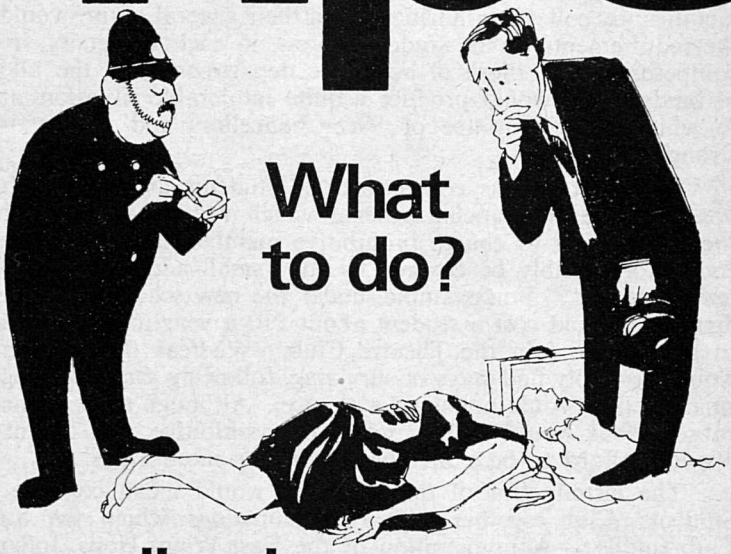
The Government has proposed changing the financing of unions as follows:—

> "(i) All students at an institution full-time or part-time would automatically be members of the student unions without payment of any fee and entitled to use its premises and facilities.
>
> "(ii) No union subscription would be included in the fees payable by local authorities and individuals.
>
> "(iii) Authorities in colleges and universities would be encouraged to measure the claims for student union facilities against other claims on their resources because each institution would be responsible for providing and maintaining union facilities from its general funds.
>
> "(iv) To meet the problem that under the present system student unions sometimes spend funds derived from compulsory subscriptions on purposes which would more appropriately be supported by the voluntary subscriptions of individual students, the student maintenance grant would be increased by a modest sum to enable students to join particular clubs and societies. At present these are financed by the union; under the new system they would charge a separate subscription and the students could pay and join, or not, on an entirely voluntary basis."

The document goes on to explain how the new system would work.

> "It would be necessary first to establish the total present amount of student union subscriptions. From this would be deducted a sum deemed to cover that part of union activities which would in future be voluntarily supported by individual subscriptions. (A small addition would be made to the student's maintenance grant for this purpose.) The resultant sum, adjusted for rising student numbers, would be added to the total 1972–77 quinquennial settlement and allocated by the University Grants Committee as part of the general grant. Each University would then be free, as with the rest of its grant, to spend it as it thought best and in accordance with its own procedures."

mps



medical
protection
society est 1892

Unlimited legal aid
and indemnity against
professional hazards
throughout the world
(except U.S.A.)

Secretary Dr. H. A. Constable. Head Office
50 Hallam Street, London, W1N 6DE. Tel: 01-580 9241
or Regional Secretary Dr. P. G. T. Ford
Regional Office: 30 Park Square, Leeds 1. Tel: 0532 42115-6

The document recognises that the proposed new system involves difficulties. "The first and greatest is to identify those activities previously financed by the union main subscription which would in future be paid for by voluntary individual subscriptions from the maintenance grant supplemented for this purpose."

The document lists the following:—

(i) Contributions or membership fees to organisations, causes or charities outside the institution (e.g., J.H.D.A., B.M.S.A., B.D.S.A., N.U.S.).

(ii) Subscriptions to individual Clubs and Societies.

(iii)The cost of other recreational activities, unless specified by the institution as suitable to be met from its funds.

The proposed arrangements for providing and maintaining union facilities, by college authorities, from their general grant, would place the requirements of the student unions, in each university, in direct competition with those of academic departments for the allocation of funds. This would produce a quite intolerable situation, and one to which the Committee of Vice-Chancellors and Principals most strongly object.

The most serious consequence to students at Guy's is the proposed split-level financing scheme which would lead to clubs and societies having to charge prohibitive membership fees. These fees could not possibly be covered by the "small addition to the maintenance grant". For example, under the new scheme, using current figures, it would cost a student about £10 a year to play rugger, £13 to row, £6 to join the Theatre Club. Whereas these larger clubs would probably find ways of surviving, following radical changes, the smaller clubs would not stand a chance. Although most of the clubs' subscriptions would in themselves be prohibitive, no student could possibly afford to be a member of two or more clubs.

The introduction of the proposals would mean collapse of the Students' Club together with those functions which the Students' Club fulfills :—Administration of the East Wing, Hops, Inflams, all cultural and social activities, the Television Room, the newspapers, duplicating services and the book exchange. If the Students' Club collapses there would be no representation of medical and dental students both inside the hospital and in the University of London

The Students' Club Council has started an active campaign against the introduction of these proposals (see Correspondence). Measures will include:—

(i) Lobbying all sectors of the college.

(ii) Sending letters to the D.E.S., the Press and the L.E.A's.

(iii) Drafting letters for students and parents to send to their M.P's.

(iv) Organising a petition.

(v) Co-ordinating with other colleges in the area, to support the day of action on 8th December.

(vi) Producing stickers, posters, leaflets, etc., in protest.

(vii) Generally trying very hard to awaken the mass of students at Guy's to the consequences of the Government's proposals.

Phlebotomy

Several months ago the grumbles about blood taking became an audible moan. This came mainly from senior students preparing for examinations, who felt that blood letting was depriving them of clinical and academic time. Junior students were in agreement. So came the inevitable survey to try to establish the time spent per week on blood taking.

Firm	No. of Students	Status of Students	Average time per student per week on blood-taking and form filling h. m.	Extra duties E.S.R.'s Portering etc. per student per week m.	Maximum and Minimum Time Spent by Individuals MAX. h. m.	MIN. h. m.
Dr. Mann and Dr. Scott	5 8	S J	5 40 5 24	50 60	6 00 6 00	3 00 3 00
Dr Hardwick and Dr. Trounce	6 7	S J	2 40 4 20	3 41	3 00 8 00	1 30 1 00
Dr. Houston and Dr. Knight	6 8	S J	2 04 2 10	11 26	2 35 6 00	0 35 0 20
Professor Lessof and Dr. Joiner	5 9	S J	1 02 2 30	0 12	1 10 3 00	0 50 1 30
Professor Sir Hedley Atkins and Mr. Ellis	8 10	S J	1 00 1 36	8 12	4 00 2 30	0 30 0 30
Mr. Lawrie and Mr. Beard	7 9	S J	2 35 1 22	13 15	5 00 4 30	0 30 0 00

The Psychiatry, Dermatology, E.N.T., G.U. and Orthopaedic firms had rotas in operation. The time taken varied between $2\frac{1}{2}$—5 hours per week. The Obstetrics and Gynaecology students did not reply.

The survey brought to light many interesting comments. It was almost unanimously felt that senior students should not have to take blood. A large number of individuals and three firms *en bloc* voted for payment of students. Only a small number of students were opposed to this. There were requests for more collection boxes, for the Haematology department to do E.S.R's. and for somebody—Housemen? Ward Receptionists?—to fill in the request forms.

The questionnaire was organised by the Student President, Lynne Hampson, whose views on the survey follow:—

1. Rather less time is spent on blood taking than was anticipated from the complaints of students.

2. The complaints are justified on examination of the maximum and minimum time spent by individual students.

3. The figures on the Mann-Scott firm coincided with a week-end take-in. High figures could be expected from each take-in firm, that is, from each firm every fourth week.

4. The Survey took place during the summer holiday, when blood taking does not clash with exam lectures. During academic terms, the length of time spent on blood taking would probably necessitate arrival on the wards by 8.15 a.m., a time which coincides with breakfast, bedpans and blanket-baths. This makes the procedures take longer and almost certainly antagonises the nursing staff.

5. Although experience in taking blood is essential for medical personnel, when it interferes with teaching, the point of being at Medical School has been missed or forgotten.

6. Blood taking is valuable as it enables the student to keep abreast of the investigations ordered and to question their usefulness.

7. The heaviest work-load is on the medical side, and the time spent in collecting blood was highest on these firms. Despite the almost unanimous feeling that senior students should not have to take blood, it would be unfair on the junior students to shift the entire work on to them. It seems reasonable to stop ALL student blood taking on the medical firms.

8. Technicians would have to be employed but in view of their scarcity would the Hospital consider employing qualified nursing staff part-time for blood taking?

9. This is not a problem unique to Guy's. Only one London teaching hospital does not expect its students to be phlebotomists, but in several the senior students are excused from blood taking. At least one other school, King's, is investigating student blood taking The results will be published when available.

10. Before negotiations with the Superintendent commence, reactions and comments from students would be most appreciated, especially on the issue of payment.

Dr. F. D. Higgs

We should like to congratulate Dr. F. D. Higgs, M.R.C.P., who has been appointed Physician Specialist to the Government of the British Solomon Islands.

Transform the Parkinsonian patient with

'KEMADRIN'

in Paralysis Agitans and Drug-induced Parkinsonism

'Kemadrin' brand **Procyclidine Hydrochloride**

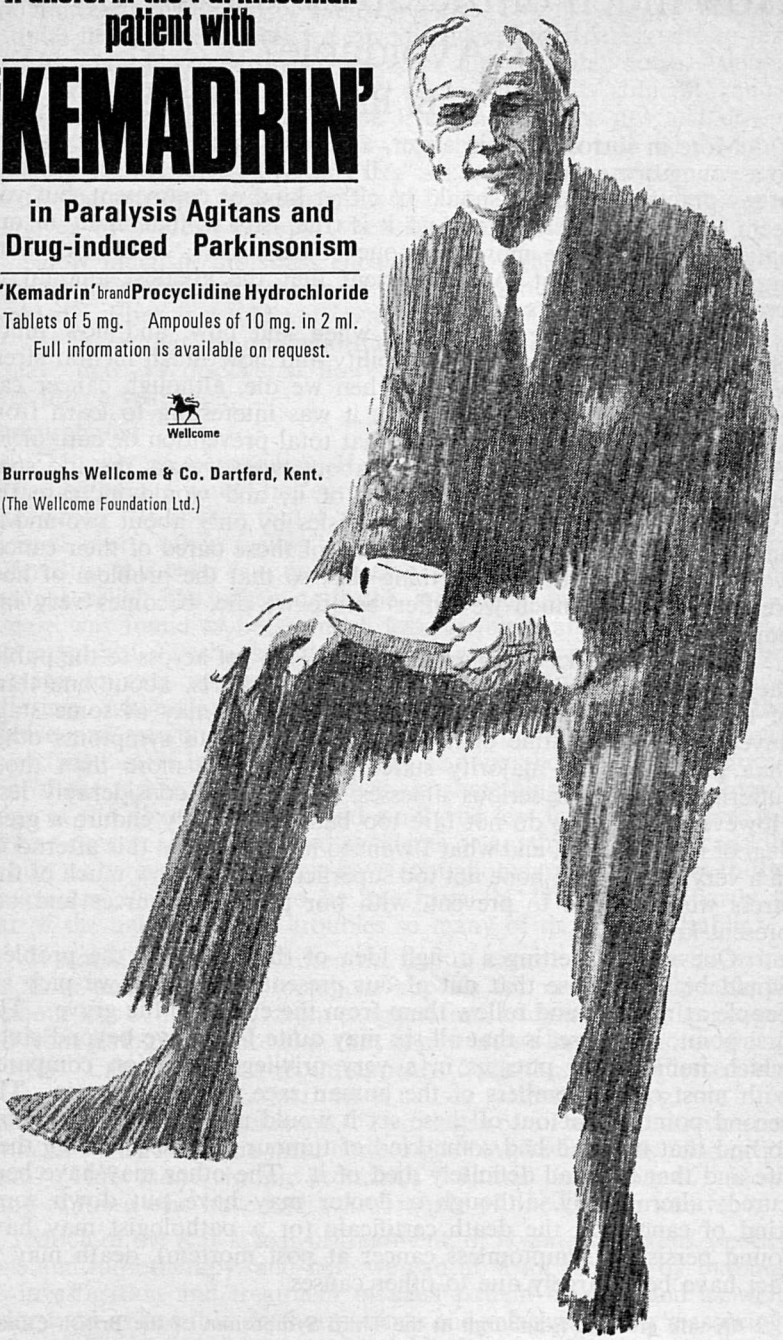
Tablets of 5 mg. Ampoules of 10 mg. in 2 ml.

Full information is available on request.

Wellcome

Burroughs Wellcome & Co. Dartford, Kent.

(The Wellcome Foundation Ltd.)



How much of the Stress due to Cancer is Avoidable? *

T. B. Brewin

More in sorrow than in anger, a general practitioner once spoke to a young doctor as follows:— "All I ask", he said, "of an assistant in my practice is that he should be either kind or competent, but you seem to me to be neither". And it is true, isn't it, that many of our patients ask for little more than one or the other. It is when both appear to the patient to be deficient that the greatest amount of avoidable stress occurs.

We all die. The question is when and how; and how much physical suffering, how much disability and how much mental stress we meet along the road. As to when we die, although cancer can often cause tragic premature death, it was interesting to learn from Sir Richard Doll a few years ago[1] that total prevention or cure of all kinds of cancer would increase by about twelve years the life span of British males who at present die of it; and would increase the average male life span in the British Isles by only about two-and-a-half years. In other words, quite a few of those cured of their cancer would fairly soon die of something else; so that the problem of how we die, and how much we suffer before we die, becomes very important.

One of the tasks of cancer education is to get across to the public the fact that although, in spite of our best efforts, about one third of those who contract a serious type of cancer may at some stage have a very rough time of it (often mainly due to symptoms other than pain), yet the majority suffer physically no more than those suffering from other serious illnesses. Sometimes considerably less. However, many who do not fare too badly physically endure a great deal of mental stress, and what I want to have a look at this afternoon, in a very broad but I hope not too superficial way, is how much of this stress we can hope to prevent, with our present resources and our present knowledge.

One way of getting a rough idea of the extent of the problem would be to suppose that out of our present population we pick six people at random and follow them from the cradle to the grave. The first point, of course, is that all six may quite likely live beyond sixty, which immediately puts us in a very privileged position compared with most other members of the human race, past or present. The second point is that out of these six it would not be at all surprising to find that two had had some kind of tumour or cancer during their life and that one had definitely died of it. The other may have been cured; alternatively, although a doctor may have put down some kind of cancer on the death certificate (or a pathologist may have found persistent symptomless cancer at post mortem), death may in fact have been largely due to other causes.

*A talk given in Edinburgh at the Third Symposium of the British Cancer Council, 3rd September, 1971.

What about the other four people in our sample? Although none had cancer and all died of something else, I would suggest that one is quite likely to have suffered severe and repeated stress due to fear that he might have contracted cancer or might one day do so. Another may have experienced prolonged stress nursing a difficult cancer patient at home; or perhaps have lived through the ups and downs of repeated recurrences over many months or years with all the emotional strain and heartache that this can mean to the relative, as well as to the patient, however grateful they both are for remissions achieved by modern therapy, when life can be enjoyed again.

How much of the stress encountered by these four people (perhaps representing two thirds of the population) could have been avoided? First, it would not be at all surprising to find, especially if he was male, that the one who died of cancer died of lung cancer, a disease that we discovered how to prevent (almost entirely) more than fifteen years ago.

Cancerphobia

Secondly, cancerphobia. If anyone thinks that fear can never be as bad as pain, I would not agree with him. Nor would Montaigne,[2] who wrote, "It is fear that I stand most in fear of; in sharpness it exceeds every other feeling". Perhaps two of our sample of six suffered in this way, one until reassurance that there was no cancer brought relief, the other until the treatment and outcome of the disease was found to be so much less terrible than his previous fear had suggested. Perhaps both delayed for months before plucking up courage to seek advice. Delay can so easily multiply stress and suffering. More sleepless nights, more fear. And fear, partly of the disease and partly of its treatment, is certainly one of the most important factors in delay. What can be done about it? If, by education of the public, we could give them something of our own knowledge of the disease, there would surely be less fear. Of course, we all fear cancer, as we fear road accidents or anything else that can kill or hurt or bereave us. But we have enough understanding of both the disease and its treatment to be free from the intense fear (partly a fear of the unknown) that troubles so many of the general public.

It would also help to lessen the fear of cancer, if those who write headlines and those who compose appeals for money could refrain (without loss of accuracy) from exaggeration, from terrifying language, and from giving the impression that at present we have little or nothing to offer. "Cancer", said a recent appeal, "chills the body. Fierce pain is often its hallmark. Sometimes it causes violent vomiting . . ." A newspaper headline proclaimed, "Two thirds of all new cancer victims doomed." Why not "One third now cured?" And what does "doomed" mean? How many chronic bronchitis "victims" are doomed? How many of those who have had heart trouble of one kind or another?

Much of the fear is fear of treatment, of hospitals, needles, operations and radiotherapy, and here we can do a lot to help by making the investigation and treatment of each patient as easy and as well understood as possible, so that patients and relatives give a reassuring account of it to their friends and neighbours.

What we do

When cancer has been diagnosed, the amount of stress suffered by the patient and his relatives can often be greatly modified by what we do, by unspoken attitudes and by what we say. No matter how early or how advanced the disease, before deciding what best to do, we need as much information as possible about the diagnosis (how certain is it? how will this particular tumour behave?), about how far it has spread, and about the patient and his symptoms. The more advanced the disease and the worse the prognosis the more attention we shall pay to a thorough assessment of symptoms (in the order in which they matter to the patient), and the less shall we be interested in worrying the patient with complicated X-rays, radioactive scans and blood tests and so on, in order to discover exactly how far the disease has spread.

Then, we have to weigh benefit against risk, often "coming to a conclusion on the basis of insufficient evidence", but doing the best we can and trying to steer a sensible course between the two extremes described by Francis Bacon[3] nearly four hundred years ago. "Physicians," he wrote in a passage quoted many years ago by Sir David Smithers, "are some of them so pleasing and conformable to the humours of the patient, as they press not the true cure of the disease; and some others are so regular in proceeding . . . for the disease, as they respect not sufficiently the condition of the patient."

In difficult cases, or where the treatment involves special danger or discomfort, who should make the final decision as to what treatment to advise? Not long ago it was being suggested that the surgeon or radiotherapist, having decided what treatment was feasible, should allow a third doctor, perhaps a general physician, to decide what was in the patient's best interest. I cannot see this. Who can weigh risk against benefit better than the doctor who has made a special study of both? Ignorance of scientific expertise does nothing to make a doctor more humane, nor will mastery of the technical side of his job make him any less so.

Euthanasia

If a patient with advanced cancer is having a bad time, and an apparently hopeless situation drags on week after week, month after month, as sometimes happens, it is argued by some that this is a situation crying out for voluntary legalised euthanasia. This difficult subject was well discussed at the Royal Society of Medicine in October, 1969,[4] not long after the House of Lords debate on the subject. I would just like to emphasise four points. First, suicide (or any attempt at it) is rare among those with physical suffering due to advanced cancer. Secondly, the better the quality of care and support, and the more the doctor or nurse are trying different ways (some traditional, some modern) of making the patient more comfortable, the less likely are the relatives to want a sudden irrevocable end to the patient's life. Thirdly, if Parliament ever decides on legalised euthanasia for a trial period, it is unnecessary—and very undesirable—for practising doctors and nurses (whatever their personal views) to have any part in the doing of it. Abortion needs a

It couldn't happen to me...

Couldn't it?

We have plenty of students on our books who found that an accident or sickness could hit them unexpectedly. Some will never work again.

But they were wise enough to take out a Foundation Policy.

It's always been an excellent way of covering basic life and sickness assurance needs for next to nothing. And we've just improved the policy.

Now we will pay you £10 a week if sickness or accident keeps you away from work for a long time. And the basic life cover is £1,000.

All for only £8 a year. Or £2 a quarter if that helps.

Isn't it time you realised that unpleasant things can happen. To anyone – including you?

Write for details of our Foundation Policy. Tell us your name, address, date of birth and approximate date of qualification. Do it now, and mark your envelope confidential.

Medical Sickness Society

7/10 Chandos Street, Cavendish Square, London W1A 2LN telephone: 01-636 1686

a member of the Medical Sickness Group

doctor and nurse. Euthanasia does not. Nor should it ever take place in our hospitals. Vague unsubstantiated fears of what may go on behind the walls of their local hospital still linger among some sections of the public. Do not let us add to this.

Finally, in the management of terminal cancer we sometimes have to raise the dose of sedation to a level that we know is not free of risk. A lower dose fails to achieve the sleep by night and the relative comfort by day that the patient and his family crave for. This is not euthanasia, any more than is the acceptance of justifiable risks in surgery or other treatment. A policy of refusing anything that is not completely safe can result in much additional stress and suffering for these patients.

What we say

Efficiency, interest, humour and respect are all valuable aids to reducing fear and stress. We want each patient to feel, "these people evidently know their job and want to help". Unlike efficiency and interest, which carry no risk or disadvantage, humour can be disastrous if ill timed, but even the roughest kind can sometimes melt anxiety like a hot sun on snow. "My doctor", said one old lady mischievously and with obvious affection, "says he has been trying to get rid of me for years with all these tablets and he can't understand why I'm still here."

Respect for the patient as a person helps to neutralise the erosion of dignity and the loss of identity which so easily occur in hospital. For the patient there is more than a fanciful similarity between hospital and prison, however much we would wish it otherwise. Solzhenitsyn makes this point in his novel, "Cancer Ward". All stripping away of clothing, all taking away of personal belongings, is humiliating to some extent. A friend (a doctor) felt almost assaulted when his wrist watch was removed on admission to hospital after a severe coronary thrombosis. It helps if we take a brief moment to ask a man about his job or a woman about her family. The older the patient, the more valuable this is. Nearly everybody is, or once was, a bit of an expert of some kind, or good at doing something.

Not everybody wants a lot of explanation. If a patient seems fairly happy, and confident that the best is being done, it may be that the less said about diagnosis and prognosis the better. Clumsy and unnecessary attempts at giving information can easily just create anxiety. But if tense, suspicious and fearful, it is often helpful to explain symptoms in anatomical and mechanical terms with minimum reference to underlying pathology, and then to outline the plan of treatment and what it is hoped to achieve. Even short-term objectives (less shortness of breath by the end of the month, a better night's sleep by the end of the week) can be very reassuring and encouraging to an ill patient.

Optimism is nearly always best and here the doctor who sees a lot of malignant disease has a great advantage over his colleague who sees only an occasional case, for he can frequently describe a similar patient, once equally ill, and now leading a normal life. Few patients

want to know exactly what their chances are of doing well. Every journalist knows that the story of one "pools" winner is of more interest to his readers than a discussion on the chances of winning. Explanation, optimism, and "suggestion", can also literally reduce pain, and assist sleep, as has been shown in several carefully randomised clinical trials.[5,6]

What we say to the patient's relatives may make quite a difference to their stress. Groundless fears or a needless sense of guilt are quite common. The family need to be told the objective of the treatment and given some idea of the chances of achieving it. Many are surprised when told that there is a very real chance of cure. What do we say if the chance of cure is small, say 5-10%? Some doctors take the view that the best and kindest policy is not to raise hopes, but to start off in such a case with the idea that the prognosis is pretty well hopeless. The other view, eloquently advocated by John Ryle in his essay on "Prognosis",[7] is to be as optimistic as the facts allow, emphasising that the situation, though very serious and uncertain, is far from hopeless. There are several advantages in taking this line, the most important of which is that a sincerely optimistic doctor will appear to be—and quite likely will be—more interested, more involved, and more concerned with the treatment and management of the case than will a pessimistic doctor. And if all concerned have begun to think in terms of comfort and a peaceful end, rather than of recovery, there is still room for optimism, but of a different kind. A determination to deal with each new symptom as it arises; a conviction that every discomfort, if it cannot be abolished, can at least be eased; a willingness to try new remedies; above all a steady maintaining of professional interest and effort.

Conclusion

Although much of the stress due to cancer is inevitable, a surprising amount can be done to diminish it. For best results we need to be both competent and kind. Perhaps in this field kindness should be looked upon merely as an essential ingredient of competence. What we say and do depends partly on what sort of person the patient is and partly on what sort of person the doctor or nurse is. Richard Asher[8] wrote that "all the power of tongue and pen, and all the wisdom of textbook and lecture, can never teach a doctor the knowledge of when to probe and when to leave alone, when to chide and when to reassure, when to speak and when to keep silent. They are private mysteries with a different solution for every one of the million permutations of personality involved between a doctor and his patient."

References

[1]Doll, R. (1967). The Prevention of Cancer (edited by R. W. Raven and F. J. C. Roe). London, Butterworths.

[2]Montaigne, M. (1580). Essays. Translated by E. J. Trechmann (1927) Oxford University Press.

[3]Bacon, F. (1957). Essays. Oxford University Press.

[4]Symposium on Euthanasia (1970). *Proc. Roy. Soc. Med.* **63**, 659.

[5]Egbert, L. D., Battit, D., Welch, C. E., Bartlett, M. K. (1964) *New Engl. J. Med.* **270**, 825.

[6]Benson, M. K., Cherry, R. J., Herxheimer, A. (1966) *Lancet*, **1**, 1239.

[7]Ryle, J. A. (1948) The Natural History of Disease. 2nd edition. Oxford University Press.

[8]Asher, R. (1955), *Lancet*, **1**, 758.

Banker's Order Form for SUBSCRIPTION

To Messrs. ..... *(Bankers)*

.....

.....

Please pay as an Annual Subscription for GUY'S HOSPITAL GAZETTE **40p** now and until further notice, on the ..... day of ..... the sum of **£2.50** to Credit of GUY'S HOSPITAL GAZETTE ACCOUNT, at the Midland Bank Ltd., (Southwark Branch), 28, Borough High Street, S.E.1, and charge same to my account.

40—06—21. **This cancels any previous order.**

Signature .....

Address .....

.....

£2 - 50 *Date*.....

To the Manager,
Guy's Hospital Gazette,
Guy's Hospital,
London Bridge, S.E.1.

Please find enclosed herewith my Annual Subscription to GUY'S HOSPITAL GAZETTE of **£2.50.**

Name (in full) .....

Address .....

.....

.....

Date .....

INCREASE IN SUBSCRIPTION RATE

The annual subscription rate to the GUY'S HOSPITAL GAZETTE has, to the great regret of the publishers, had to be increased by a small amount to meet advances in production costs and greatly increased postal charges which have made the present rate uneconomic. The single copy price of the Journal has been raised at the same time from 10p to 12p.

New subscriptions taken out after 1st November, 1971, will be increased by 40p to £2.50 per annum.

We respectfully ask subscribers, who pay by Bankers' Order, to fill in the form opposite (top) and send this to your bank as soon as possible. We must apologise for this step but we hope you will still continue to support us and to enjoy our journal.

Subscribers paying by cheque are requested to fill in the cash form opposite (bottom) and return this to us.

J. PATTERSON,
Manager.

NURSING SECTION

The Right to Marry?

One of the greatest enigmas to be observed amongst nurses today, is the attitude currently prevailing towards married women who wish to work either full- or part-time in the hospitals.

It is a well-known fact that this country is desperately in need of trained staff. In the teaching hospitals the situation is frequently at a level that could only be described as dangerous. However, in the smaller hospitals this is not the case. Why is this? And is there something which they can teach about it?

It would appear that the smaller hospitals long ago came to terms with the fact that they could not maintain a service along the traditional lines of a staff composed completely of spinsters. They therefore regarded the problem, and then introduced schemes designed to encourage the return of married nurses to the profession.

The first requirement here is, of course, flexibility of working hours. At the same time this has to be equated with the fact that everyone cannot have every week-end free. However, by treating employees as individuals it is usually found that most are extremely co-operative. Next, of course, there are the children to be considered. To this end, many hospitals now finance and organise most efficient crêches, which are designed to cater for the strange hours worked by the mothers. Incidentally, because these crêches are open to all grades of staff the quality of clerical and secretarial staff frequently improves.

As a result of this, the hospitals who have undertaken to do this have improved their staff complements considerably.

Why then do the larger hospitals not embark upon a similar scheme? Firstly it would seem because there is still open antipathy towards those who are married. It appears that if one becames a nurse, the right to fulfil one's normal biological function is automatically denied. Those who do marry and remain at work are usually considered unworthy and have to prove themselves reliable before being accepted back into the community. It is almost as if marriage has the effect of changing one overnight from someone reliable, into one who is fickle and dilatory. As a result of this attitude, many married nurses who offer to return to work because they feel they could be useful members of society are, not very politely, told that their services are not required.

In addition to this, these attitudes are perpetuated by the nurses' own professional organisation which refuses admission to certain of their training courses to married women. Again in a most uncivilised fashion.

The excuse given by many large hospitals for refusing to employ married staff is that people will not be prepared to travel into Central Urban areas to work. This is, of course, a mere veneer for the true reasons.

Is it not time that attitudes changed? The hospitals are desperate for staff and yet will make no effort to relieve the strain on their overpressed workers. Why should a married woman have to prove her worth? She is probably more reliable than her unmarried colleagues. After all, she is less likely to disappear suddenly, as her journey to the altar is over! She will probably have more understanding of young nurses and of the patients if she already has a family.

There is surely here a large untapped source of labour. With a little planning it could be effectively utilised and provide satisfaction for those employed and less worry for the employers.

If it became recognised that married women could be employed in hospitals then more would apply. At present, many do not attempt to return owing to the reception they know they will receive. One nurse even wrote to *The Times* on this very subject recently.

It does, however, seem strange that in this day and age when married women are encouraged to return to every other type of work, those who are unfortunate enough to be nurses are steadfastly rejected. In a profession with a female, largely unmarried labour force, may there not be a moral here?

NOTICES

THE HUME KENDALL TRUST

Readers may like to be reminded of the existence of this Trust which was established in 1968 as a permanent memorial to the late Patrick Hume Kendall, Consultant in Physical Medicine at Guy's, who died at the age of 41, leaving a wife and three sons of school age. The purpose of the Trust is to offer financial assistance to any "Guy's Man" who, by reason of permanent ill-health, is obliged to retire prematurely or to the families of any "Guy's Man" who dies before attaining normal retiring age. The education of children, including training for a profession, is of particular concern to the Trust.

In addition to helping with the education of Pat Kendall's family, in the short interval of three years since the formation of the Trust, advice and/or financial assistance has been given in four other instances—one instance of permanent ill-health and three instances of premature death. Although Guy's trained, none of these "Guy's Men" were currently on the staff of the Hospital but all had children whose continuing education needed to be considered.

The Trustees, who include Senior Members of the Medical and Dental Staff of the Hospital and the Schools, would be grateful for any help by way of donations, deeds of covenant or testamentary provision and enquiries concerning these or assistance from the Trust should be addressed to the Honorary Secretary, Mr. E. Warburton, Chief Accountant, Guy's Hospital, London, S.E.1.

DERMATOLOGY PRIZE

A new Fund has been set up in the School—the Dermatology Fund—as the result of a private appeal by Dr. R. S. Wells. To date, through Dr. Wells' efforts, £2,000 has been donated to the Fund, the prime object of which is to endow Dermatology Prizes for Guy's clinical medical students.

There will be a First Prize of £15 and a Second Prize of £10 for the two students who show themselves to be most proficient in tests at the end of the Dermatology appointment, and further prizes of £15 and £10 for the two best of the quarterly prize-winners during the year.

The new quarterly prizes are being awarded for the first time to students who completed their Dermatology appointment in October, 1971.

THE HOSPITAL SERVICE OF LESSONS AND CAROLS

in the Chapel

on TUESDAY, 14th DECEMBER, 1971,

at 7.30 p.m.

CHRISTMAS SHOW 1971

Free tickets are now available for this non-stop comedy show from D. Mayer, c/o East Wing.

The production is on the **13th, 14th, 15th, 25th and 27th of December.**

Proceeds are to be given to the Children's Ward.

GUY'S HOSPITAL CHRISTIAN UNION

All members of the hospital community are invited to an evening of Carols and Christmas Music entitled "Christmas —A Backyard Miracle," on **Monday, 13th December, at 7 p.m.** in the North Common Room. Guest performers will be the New Freedom, a Christmas Folk Group, and Nigel Goodwin, an actor at present running a Christmas Arts Centre in London.

CORRESPONDENCE

Gazette, 20th November, 1971

SIR,—May I endorse most heartily, and with a history of more than ten years strenuous endeavour towards the same end, the theme of the opening section of PASSIM (Mingle, You That Mingle May).

May I also add to the admirable references appended to the equally admirable article on DEATH by Marcus Pembrey one single omission, not yet available when that article was first written, 1966:

> CARE OF PATIENTS WITH FATAL ILLNESS, Annals of the New York Academy of Sciences, Vol. 164, Art. 3, Pages 635-896, New York, December 19, 1969:

and pay yet one more tribute both to the excellence of the nursing section, and the entertainment as well as the compassionate insight of some of the correspondence.

Finally may I venture to suggest that the Guy's Society for Social Responsibility in Science (page 608) has contrived a peculiar degree of irresponsibility for once; since understanding of the human brain is still so far from anything approaching completeness, then "The Dreams and Doubts of a Brain Research Worker" are likely to be singularly dreamy as yet: while the other lecture on 2nd December, 5.30 p.m. would probably be funnier and less pretentious if it was given by Spike Milligan in person rather than the earnest and well intentioned Chairman of the Arbours Association, whose aims would be more recognisably absurd if they included attempts to stop sick and unhappy children being treated at all.

Yours sincerely,

D. STAFFORD-CLARK

York Clinic,
Guy's Hospital,
London, S.E.1.

SIR,—I was most interested in Dr. Marcus Pembrey's article on Death in the last issue of the *Gazette* and in his list of references. May I claim space to add one more?

I refer to the chapter entitled "The Needs of the Dying Patient" in the 18th edition of the late Evelyn Pearce's "General Text-book of Nursing" an advance copy of which was placed in her hands literally hours before her own death at the age of eighty-four.

In a few brief paragraphs this great woman and great nurse distilled the wisdom of over half a century of experience of nursing and of teaching nurses, and should be pondered by all whose vocation may call on them to care for the dying.

I am,

BRIAN D. JOHNSON

443 London Road,
Leicester, LE2 3JW.

Clinical Lectures

SIR,—You have been kind enough to refer to the systematic course of Clinical Lectures which Dr. Joiner has organised. Perhaps your readers might like to note that these will continue to be held every Thursday at 1 p.m. for a trial period of three months. Provisional plans have been made which, if the series is well received, could continue this programme over a period of two years. In that event, it may be possible to co-ordinate the timing of different parts of Dr. Joiner's course with the teaching arrangements for pathology. No doubt a certain amount of teaching on clinical physiology will also be available.

Dr. Stewart Cameron has kindly offered to make tape-slide recordings of selected talks in the series. These may in time be added to the other records which will be available for revision purposes.

Yous faithfully,

MAURICE LESSOF

Department of Medicine,
Guy's Hospital Medical School,
London, SE1 9RT.

The Ward Sisters

SIR,—I fully support the views of your recent correspondents (John and Ursula Kilby) on the need for raising the status of the Ward Sister. A lot of lip service is paid to this matter, but when decisions are made on policy which intimately affects the Ward Sister, not only is she not invited to such meetings but her so-called representative (through no fault of her own) neither represents her nor has she had the opportunity of discussing the matter previously with the Ward Sister.

Surely the Ward Sister is an administrator as well as a clinician (she administrates her ward) and is in the best position to contribute with the nursing administration to policy decisions which affect the running of the wards. If the Ward Sister is involved in this way. we will help to eliminate the real gap between administration "they" and the Ward Sister "us" which is threatening to appear and to interfere with the relations between the various areas of the nursing profession.

Yours sincerely,

M. C. JOSEPH

Department of Paediatrics,
Guy's Hospital,
London Bridge, S.E.1.

Linda Titley

SIR,—As a former matron of Guy's Hospital with the longest period of service, 1927-1946 within the last hundred years, I would like to put on record that our Founder, Thomas Guy, has been fortunate in adding to the list of his loyal servants and senior executives on the Nursing side of the hospital, the name of Miss Linda Titley. She came back to her old hospital in a moment of need.

No one knows better than I, the problems to be faced and the variety and wide scope of a hospital matron's responsibilities and influence. There are, I know, many past Guy's nurses who would wish to join with me in an appreciation of Miss Titley's short but valuable period of service—1968-1971 as matron of Guy's Hospital.

E. R. MACMANUS

Terry Lodge,
Terrybawn,
Bofeenaun,
Balluia, C. Mayo.

White Coats

SIR,—Once upon a time there was a medical student who was a late developer. He eventually became so tall that no white coat fitted him any more and he had to do without.

Instead of being a sad, deprived doctor because of this, he noticed that young children were glad, instead of upset to see him, which took him back to the happy times he had had with them in the days before he wore a white coat.

Yours sincerely,

P. A. GARDINER

Guy's Hospital,
London, S.E.1.

SIR,—Whilst welcoming the introduction of white coats—long overdue—I am a little concerned about the arrangements for laundering them.

The figure of 40 washes per year is interesting. By mathematical calculation this works out at less than one wash per week. I would have thought at least two washes per week would be required. If the School is going to subsidise the laundering they should do the job properly. Are the coats to reduce cross infection or increase it; or to make us look respectable or grubby by the end of the week? Half a loaf is better than none, but why do things by halves?

Now that we are to have white coats, let us now have nameplates. A standardisation of the present haphazard system would be most beneficial.

Yours sincerely,

JONATHAN E. M. FOX

East Wing.

Students' Club Council on the D.E.S.

SIR,—At a meeting of the Students' Club Council on Friday, 26th November, 1971 the following motion was passed to be advanced for approval to an Extraordinary General Meeting of the Students' Club to be held on Friday, 3rd December at 1.00 p.m. in the Ballroom of the East Wing.

The Motion is "that Guy's Hospital Students' Club strongly opposes the proposals in the consultative document 'The Financing of Student's Unions' by the Department of Education and Science as having the effect of weakening and dividing the student movement."

The proposal to finance student activities through the college authorities and to employ a voluntary subscription basis for all the clubs and societies in the "Union" would destroy the financial viability of the clubs and the educational and representatives role of the Union.

If implemented the proposals will effectively destroy Student Unions, particularly in Colleges of Education.

Yours faithfully,

J. P. C. MCGLONE
Hon. Student Secretary

Guy's Hospital Students' Club,
East Wing.

Students' Reaction to the D.E.S. Report

SIR,—By the time this page is reached, the reader will be more aware of the implications of the proposed government "curb" on Students' Unions.

Far from suppressing student radicals such legislation will antagonise and alienate the far larger body of moderate students, such as ourselves, who will be considerably affected.

The aim of a university is to educate not chain. The extra-mural activities being as important as, if not more so, the main subjects—the old maxim "All work and no play makes Jack a dull boy," could not be more apt. The proposals, by starving clubs and societies of their finances, would completely abolish an integral part of university life.

Surely, a course should be tailored to some extent to the student population at the time. Just because a particular antibiotic cured an infection last week does not mean that the same course will be effective in future. The beasties, like students, change. Abolition of Students' Union means abolition of student voice and hence feedback on the suitability of the course.

Objections are not just from power-mad students, afraid of losing their grip, but from university authorities who also foresee the disastrous consequences which could arise if the proposals were implemented.

Yours sincerely,

LYNNE HAMPSON,
Student President.

East Wing,
Guy's Hospital.

SIR,—Much information has been given about the effects of the proposal in the DES consultative document on Student Unions, in particular to the clubs and societies in Guy's. But one wonders what the restives behind the proposals are.

The London University Vice-Chancellors' letter to the government condemned the document, saying that although the defects in the present financial structure of the Students Unions were appreciated, the proposals did not seem to solve the problem in the most satisfactory way: if instead the local education authorities control was transferred to the Universities Grants Committee, as a "ear marked grant" the same protection of public funds would be achieved and still leave union subscriptions compulsory.

So it would seem that the Conservative Government wishes to have union fees voluntary for the specific purpose of weakening and dividing student unions.

Their reasons for this may be manifold, but is it not feasible to suggest that not only are they unconcerned with the survival of student clubs and societies, but also, in light of their policy on trade unions, that they wish to prevent student unions from becoming platforms for political factions of opposite views to their own ?

Surely this is not the kind of democracy expected of any government elect.

Yours etc.,

T. J. GOULDER

East Wing,
Guy's Hospital.

Christmas Boxes

SIR,—May I, through the *Gazette,* thank all those who kindly brought gifts to the Hospital's Harvest Festival, and, as Christmas approaches, make the usual appeal for gifts at this time. Boxes will be placed in various parts of the hospital, and gifts of Christmas food are most welcome. There are still many people living alone and in poverty in the Borough, and I know that they appreciate the "extras" that we are able to take them in Christmas parcels. We hope to distribute these soon after the Hospital Carol Service on 14th December.

Yours sincerely,

ROBERT KEMPSTER
Chaplain

The Chaplain's House,
11 St. Thomas Street,
London, SE1 9RY.

O 'Tis Cramped In The Lift

SIR,—As I am sure you are aware, there is an endless stream of meal trolleys, laundry baskets, etc, etc, using the passenger lifts in New Guy's House. I wonder if there is any possibility of a complete ban on service loads in these lifts, as the service lifts, situated in the emergency staircases, could easily cope with the traffic. Such relief of unnecessary loads in the already inefficient passenger lifts would be welcomed by all users of the Surgical Block.

Yours etc.,

M. ST. G. WHEELEY

East Wing,
Guy's Hospital,
London, SE1 9RT.

SPORT

GUY'S CANOEISTS COMPETING FOR U.L.

On the cold weekend of 13th-14th November, two Guy's men competed for the University Canoe Club in the Exe descent race. This race is 19 miles long and has many obstacles to overcome, mainly eight weirs of up to 12 feet in height to shoot. This year, the water was low and therefore dangerous to boat hulls in the many rapids. Two-hundred-and-fifty people took part in about 10 classes.

Gordon Yeates made his debut as a long-distance and white water paddler by coming 20th out of 47 finishers in his slalom boat class, in a time of 3 hours 24 minutes, beating many more experienced paddlers.

Barry Jones, the U.L.C.C. secretary, paddled in the K2 (International racing doubles) class with a partner from I.C., to come 5th out of 15 starters and 11 finishers in a time of 3 hours 9 minutes. The four boats that failed to finish broke into many pieces on the weirs, delighting crowds of up to 400. The winners in fact carried their broken boat two miles to the finish, threw it in and jumped after it, swimming over the last few yards to win.

This race was a national ranking race for K2's and was the best result for the U.C. pair, putting them about a third of the way up the national ranking.

Canoeing is a varied and interesting sport and anyone interested should come to the U.L.C. pool on Wednesday evenings, 8.30 p.m., where tuition is available.

B.J.

HOCKEY

LONDON UNIVERSITY SIX-A-SIDE COMPETITION

Guy's Lose in Final

Guy's Hospital fielded a strong squad for the annual six-a-side competition at Motspur Park. Considering that there had been no practice beforehand, the 1st VI settled down very well in the first match against Northern Polytechnic. Guy's quickly dominated the field and goals by Robert Forber and Bob Clark (2) gave the side a convincing 3—0 win.

However, the side looked much less settled in the second match, against Q.E.C., and an unimaginative, scrappy display only brought one scraped goal and a flood of near misses.

The two wins and a "walk-over" from Queen Mary College II saw Guy's through to the quarter-finals, where the same scrappiness and poor co-ordination only allowed the side to reach the semi-final on short corner assessment. It was the same old story of complete domination of the opponents (Thames Polytechnic) but no goals to show for it.

More comfort, however, could be derived from a sound performance against Bart's in the semi-final. Guy's moved the ball with more urgency against a side much fancied to win the competition. The first wave of attack brought a short corner, and Bob Clark managed to deflect Bob Fells' well-struck shot past the 'keeper.

The inability to play six-a-side style hockey caused the final to be lost to St. Thomas's 0—3. This side, almost the same as that which won last year, used the sound tactic of keeping one man out on the right wing: an example that Guy's might well follow next year.

Guy's 2nd VI caused a major upset in their first game by knocking out U.C.H. firsts 1—0. A goal by Dave Cole in the last minute, following a cross by Jeremy Horton, was hard luck for a U.C.H. side that had done everything but score. The extra spirit of the 2nd VI was of no avail, however, in the next round when they lost to Queen Mary College 0—1.

Teams: 1st VI: B. Lakhani, P. Nicol, R. Burns, R. Fell, R. Clark, R. Forber.
2nd VI: C. Crawshaw, J. Walker, J. Sparrow, J. Horton, D. Milliner, D. Cole.

R.F.

GUY'S v. GRAVESEND

Result: Guy's 2 Gravesend 0.

Yet again John Walker scored the vital goal half-way through the first half shooting well from the edge of the circle. Despite the contortionate efforts of the Gravesend 'keeper to turn it wide, he could only manage to steer it inside the post.

This was certainly a good win but Gravesend were unlucky not to score. Only some excellent tackles by Lakhani and close marking and anticipation by the half-backs, especially Rebello, prevented a less satisfactory scoreline. John Cottingham made several first-class saves including a fine piece of quick-thinking at the near post when he actually threw the ball off.

For the first time this season no goals were scored against, Nicol and Lakhani having few problems that were not due to the bumpy pitch. Wilmer used his speed well on the left wing but found his feet in the way when he tried to cross it. He combined well with Clark and Walker and earned the corner from which the second goal came. Robert Clark hit the ball as sweetly as any this season and it was in the net before sticks could be given.

Altogether this was a fine all-round performance for Guy's with no outstanding players. It should be a good omen for the next few testing games.

Team: J. Cottingham, B. Lakhani, P. Nicol, R. Kendrick, T. Rebello, C. Crawshaw, P. Wilmer, J. Walker, R. Clark, R. Burns, J. Horton.

R.B.

GUY'S v. KINGSTON G.S.

at H.O.P. 30th October

Lost 2—4

This was a disappointing game in that only one goal of the six was scored in open play. This goal came in the first five minutes when the skilful schoolboys of Kingston worked a move down the right wing. This move was assisted by Guy's equally skilful non-marking, leaving the Kingston inside right a simple shot six yards out of goal.

Kingston continued to press forcefully, and deserved to be 2—0 up at half-time, the second goal being the result of good short corner drill and poor goalkeeping.

In the second half Guy's came more into the game, and looked dangerous when going forward down the right wing, however another 'keeping error led to a flick which put Kingston 3—0 ahead.

Guy's hit back at last through the lucky Clark. He managed to tap the ball twice on successive short corners. Amazingly, the ball went over the line in each case, although Clark swears blind that he meant it to happen.

In between the antics of our centre forward, and despite the solid Nicol who played his usual reliable game at the back, Kingston struck again through another short corner, to make the final score 2—4.

Team: J. Cottingham, P. Nicol, B. Lakhani, C. Crawshaw, P. Willmer, N. Matthews, R. Burns (capt.), C. Handler, J. Walker, R. Clark, J. Horton.

J.C.

GUY'S v. ST. MARY'S

Won 5—0

Guy's, the defending champions, met St. Mary's in the first round of the U.L. Cup. St. Mary's had a weak side and within seconds of the start Guy's nearly scored.

The match was a procession of Guy's forwards taking the ball into the circle and shooting towards, over, around, and occasionally into the Mary's goal. In spite of the fact that five goals were scored, one was left with the impression that it could so easily have been double or treble that, if safety rather than spectacle had been the watchword. Still, a good win is a pleasant change this season so one shouldn't complain.

Team: J. Cottingham, P. Nicol, B. Lakhani, T. Rebello, R. Fell, C. Crawshaw, R. Forber, J. Walker, R. Clark, R. Burns, J. Horton.

P.N.

RUGBY

GUY'S v. LOUGHBOROUGH COLLEGES

Result: Lost 16—46

Contrary to the result depicted at the final whistle, the Guy's XV played well for the greater part of this game with the superior fitness of the physical education college telling in the end. Better tight scrummaging and line-out play by the Loughborough forwards somewhat left the Guy's backs with a lot of tackling and few good scoring opportunities.

Loughborough kicked off into the wind and some very good rugby followed from both sides. Guy's appeared to have the upper hand at this stage and soon went ahead with a fine converted penalty by Novak. With this as credit Guy's attacked and were unlucky not to score after some good running by the backs following a tight scrum. Another penalty from the half-way line converted again by Novak put Guy's 6—0 ahead.

Following a clean catch in the line-out and some good running by the Colleges stand-off who ran through too many Guy's players, the scores were brought level. The exact same movement 5 minutes later rewarded Loughborough with a 12—6 lead. Not discouraged the Hospital XV came back and following another penalty by Novak the lead was reduced to 12—9. By half-time with a penalty to Loughborough easily converted Guy's were trailing 15—9 but still very much in the game.

With two quick converted tries by the Colleges following a defensive lapse by Guy's the situation became irretrievable. Despite further valiant attempts at penalty goals by Novak, Loughborough went further ahead with a well taken drop goal from the back of a set scrum.

30—13 ahead Loughborough still had time to dispute the referees decision resulting in another penalty for Guy's which Croft converted to complete the hospitals total. Loughborough, however, went on to score three more tries, two of which were converted to arrive at the final result.

Team: D. Jones, R. Barrough, T. Druett, P. Board, A. Campbell, T. Owen, C. Croft, D. Rosewall, T. Gibson, N. Allen, R. Burt, D. Stuart, J. Novak, T. Fallowfield, R. Massey.

J.A.C.

ARTISTS v. LONDON SCOTTISH

Saturday 30th October

Result: Artists 44 London Scottish 6

Having lost narrowly in the first match of the season, the Artists (a side started last year mainly by 2nd M.B. students) proved, with an overwhelming victory against a London Scottish side, that they are here to stay.

The fault in the first match was a lack of co-ordination, and this was rectified on Saturday by some co-ordinated pre-match thinking, when the tactics were planned.

From the very start the Artists proved their superiority and a try was scored early on, which really started the ball rolling! The side does not lack talent, but on Saturday everyone played extremely well (including Wheeler, playing only his third ever game of Rugby—all for the Artists). In the pack Meakins, McLeod, Gray and Killick all played especially well. Green and O'Donnell provided a stimulating half-back pair and Lewis, despite being labelled as effeminate by a car-park attendant, showed us some beautiful thrusting runs between the opposing centres, Wyn-Jones and H. Jones played well on the wings, and Langdon managed to convert one or two of the tries.

In the last few minutes Jones had to leave the field (he has not yet finished a match for the Artists), and because of this the opposition scored an unexpected try.

We were satisfied even more in the bar afterwards, when their Skipper came up and said that he thought we were probably a better side because rather more of us knew how to play Rugby than them!

C.L.

HOSPITAL INFORMATION

GUY'S HOSPITAL BOARD OF GOVERNORS

Applications are invited for the appointment of locum paediatric registrar at the Evelina Children's Hospital for the period 1st to 9th January, 1972 inclusive. Applications should be sent to the Superintendent, Guy's Hospital, London SE1 9RT, with one week.

GUY'S HOSPITAL BOARD OF GOVERNORS AND THE SOUTH EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited to fill an established vacancy as **Senior Registrar** in general medicine to the Board of Governors of Guy's Hospital and the South East Metropolitan Regional Hospital Board commencing on 14th February, 1972 until 30th September, 1974. The appointment will be made jointly by the bodies concerned and the period 14th February to 30th September, 1972 will be spent at Lewisham Hospital. The post which will be reviewed at the end of the first year, is subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff (England and Wales). Forms of application are available from and should be returned to the Superintendent, Guy's Hospital, London, SE1 9RT, not later than **17th December, 1971.**

ORPINGTON HOSPITAL, KENT
TRAINING IN ORTHOPAEDIC SURGERY

Two Senior House Officer posts will shortly be vacant at Orpington Hospital, where the officer will receive a systematic course of theoretical, practical and operative training. A full spectrum of Orthopaedic and Trauma surgery is undertaken, and the S.H.O. will be expected to participate in tutorials and journal analysis sessions. Primary F.R.C.S. desirable but not essential. Duties will be in wards, operating theatres and casualty department on a rotating basis. Candidates may visit the hospital and discuss their interests with Mr. S. J. S. Lam, Consultant Orthopaedic Surgeon. Orpington Hospital, Kent.

PERSONAL

CORNWALL—Opportunity for a 4th practitioner to purchase into an expense sharing association, all Guy's. Low seater equipment with own X-Ray. Full staff. High professional standards are considered more important than high turn-over. Potential for increased private work is good in this area. Good schools and excellent recreational facilities. Box No. 1/12.

CHANGES OF ADDRESS

Drs. Peter and Jean Firth, Hurstwood House, Hurstwood Lane, Haywards Heath, Sussex.

Dr. and Mrs. F. D. Higgs, Medical Department, P.O. Box G.349, Honiara, British Solomon Islands.

Dr. and Mrs. J. Wheeler, The Coach House, Holmer Court, Holmer, Hereford, Herefordshire.

BIRTHS

EDGAR—On 29th October, 1971 to Anthea (née Sutton) and Ashley Edgar a son, *Barnaby, a brother for Nicholas.*

MORRIS—On 1st November, at Walsgrave on Sowe, Coventry, to Rosalind and Ian Morris a daughter, Helen Charlotte.

MARRIAGES

SANDERSON—GREENWOOD — On 29th October, 1971 at Quaker's Friars, Bristol, Mr. Arthur Sanderson to Dr. Susan Greenwood.

WHEELER—LAMPDEN—On 30th October, 1971, at Penhurst, Kent, Dr. Julian Wheeler to Miss Pippa Lampden.

PAPERS BY GUY'S MEN

Abrams M. E. Computers with regard to surgical records and notes. *British Journal of Surgery*, 1971, **58**, 783.

Hunter, D. Centenary of the birth of Robert Hutchinson. *British Medical Journal*, 1971, **4**, 222.

Morris, A. and others. Coagulation disturbances after Dextran. *Lancet*, 1971, **2**, 925.

Northfield, T. C. Oxygen therapy for spontaneous pneumothorax. *British Medical Journal*, 1971, **4**, 86.

Preiskel, H. The canine teeth related to Bennett movement. *British Dental Journal*, 1971, **131**, 312.

Watson, D. M. A new towel-clip. *Lancet*, 1971, **2**, 906.

Wharton, C. F. P. and others. Changes in left ventricular wall movement after acute myocardial infarction measured by reflected ultrasound. *British Medical Journal*, 1971, **4**, 75.

We would like to remind our readers that all copy for inclusion in the "Gazette" must be received eight days before publication date.

Copy may be sent to us c/o The Front Lodge, Guy's Hospital.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, please indicate whether or not this should be published.

Personal notices 5p per word (pre-paid) (minimum £1.05).

Non-subscribers will pay £1.05 (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

EDITORS A. M. TURNER and J. L. LEWIS
NEWS EDITORS C. G. CHINERY and D. I. F. KELLEHER
SPORTS CORRESPONDENT R. W. BURNS
NURSING CORRESPONDENT Miss P. M. JEFFERIES
BUSINESS MANAGER Mrs. J. PATTERSON

FORTNIGHTLY TWELVE PENCE VOLUME 85 NUMBER 2177

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Christmas is a time for reassurance; a time for indulging again in the childhood confusion between the gift-providing Santa Claus and a benign God. It is a ripe time to consider an answer to Pope's question:

> "Say first, of God above, or Man below,
> What can we reason, but from what we know?
> Of Man what see we, but his station here,
> From which to reason, or to which refer?"

It is not necessary to dwell on any particular tragedy of the year. The British Government has been reduced by horrifying violence to interning prisoners in Northern Ireland without trial. A commission of inquiry into the treatment of those prisoners required a distinction between ill-treatment and brutality to excuse the way those prisoners were dealt with in goal. A violent situation exists there for which precious few reasonable men can see any solution at all.

Mrs. Gandhi, remember the name and the philosophy with which it was once associated, leads her country in a fight against her neighbours; a fight that follows a reported migration into India of starving refugees whose number is roughly equivalent to the population of London. Both the Indian and the Irish struggles are the result of the inadequate solution of partition to solve differences that have existed for centuries.

China and Russia, unable to risk outright fighting between their two countries, have taken the opportunity of using the quarrel between two other different countries to express their violent enmity for one another.

In the Middle East the piles of arms supplied by the rich nations of the world increase on either side of precarious borders.

It has not been greatly noticed of late but the war in Vietnam continues. One hopeful light exists in that President Nixon has admitted that the previous governments of the United States of America were in error to increase the war in Vietnam to such ghastly proportions. He has not, however, also declared an apology and free pardon to those who refused to fight in that war that they repeatedly said was wrong.

It is difficult to share the optimistic conclusion that "One truth is clear. Whatever is, is RIGHT." Perhaps our only hope is to maintain awareness of our individual ghastliness and ensure that in our personal relations we do not make the same mistakes.

The *Gazette* wishes all readers, and non-readers, a Happy Christmas.

Unbeknown to the editors, an edition of Private Guy has slipped between the covers of the Christmas edition. For their help in this special offer we wish to thank Mike Rose, Mike Simpson, Andrew Seal, Nigel Bax, Richard Darling, Jane Eadie, Michael Lavelle and Peter Lewis.

What Would Walt Disney Say ?

Not very long ago, Kenneth Tynan had the distinction of breaking the four-letter word barrier on television. It created a minor stir but the incident passed with comparatively little comment. The door was opened and "bad" language was being transmitted into millions of homes. Dramatists regarded it as the first step towards freedom of expression in the English language. Dialogue in films or plays would no longer be limited by outdated codes. "Realistic" characters could speak "realistically".

The stage was the first medium to make use of liberalised language and actions. "Hair" opened three years ago and boasted not only rock music but (at that time) daring language and a mass-nudity scene. It was a tremendous success and has had many imitators (including a Residents' Play). Most of these failed probably because the novelty had worn off. Perhaps, swearing, nudity and sex alone are not enough for a theatre audience.

Films have particularly been affected by the new dramatic licence. "Skin films" which were previously only seen in back-street cinemas or clubs now appear in the High Street. The "quality" films made in recent years have broken away from the self-imposed morality code of the Hollywood studios and have become disturbingly expressive in nudity, sex, and violence.

The new freedom can be used with great impact towards a dramatic end. The final violence in "Bonnie and Clyde" performed as it was, communicated more than dialogue could. If half-measures had been taken, the scene would have failed.

Films such as "The Virgin and the Gypsy" or "Women in Love" could not have been made if the directors were limited to embarrassed fade-outs to avoid nudity. The motivations, actions and agony of the characters are made much more believable.

However, films such as these are technically very difficult to make. Even the best director can fall into the trap of glorifying the violence he set out to condemn; violent death in a strange way has become beautiful and accepted as such. Sexual permissiveness can be abused with unnecessary sex scenes written into scripts in the hope of attracting larger audiences. An undesirable transformation has taken place because violence and sex have become the drama rather than part of it.

NEWS IN BRIEF

Dental Scholarship

The Emmott Foundation has approved an annual grant of £800, subject to periodical review, for an annual award to be known as "The Alfred Rycroft Memorial Scholarship in Dental Surgery". This will assist undergraduate students at Guy's Hospital Dental School to spend a period overseas, preferably in the United States of America under the School's exchange scheme. The Scholarship is in memory of the late Alfred T. Rycroft, who qualified from Guy's in 1910.

Principal Nursing Officers

We are pleased to announce the appointment of Miss Betty White as Principal Nursing Officer, General Division, with effect from 1st December, 1971. Miss White will be responsible for the management of nursing and midwifery services at Guy's Hospital and Evelina Hospital.

Miss B. Brysson-Whyte, Principal Nurse Tutor, has been appointed Principal Nursing Officer, Education Division, with effect from 1st December, 1971. She will be responsible for the integration of all nurse training programmes in the Guy's Hospital Group.

White Coats

Messrs. J. & L. Armitage Ltd. will be in attendance for the receipt of orders for white coats in the Table Tennis Room between midday and 2 p.m. on Tuesday, 21st December.

Students are reminded that this is the last time that a representative will be here before 1st January, when the wearing of white coats will be compulsory.

GUY'S DIARY

DECEMBER

20	M	1.00	Clinical Lecture. Dr. CAMERON. "Why doesn't everyone have urinary infection?"
31	F	1.00	Clinical Lecture. Dr. KEEN. "Diabetic Retinopathy."

Christmas Arrangements 1971

Tuesday, 21st December	
4.00 p.m.	Diplock Dressers' Tea and Ward decorations.
Wednesday, 22nd December	
4.00 p.m.	Dressers' Tea and Ward decorations.
Thursday, 23rd December	
4.00 p.m.	Dressers' Tea and Ward decorations.
Friday, 24th December	
11.30 p.m.	The Blessing of the Crib and the Midnight Eucharist in the Hospital Chapel.
Saturday, 25th December	
5.45 a.m.	(Tea and biscuits in the Dining Room)
6.00 a.m.	Nurses' Carols in the wards.
7.00 a.m.—7.40 a.m.	Breakfast in the Nurses' Home.
7.45 a.m.	Day Nurses on duty.
8.30 a.m.	Holy Communion in the Hospital Chapel.
10.30 a.m.	Christmas Morning Service in the Hospital Chapel.
12 midday	Patients' Christmas Dinner.
1.00 p.m.—2.00 p.m.	Resident Domestic Staff to lunch in the non-resident Staff canteen.
1.00 p.m.	Nursing Staff Christmas Dinner in the wards.
3.30 p.m.—4.30 p.m.	Patients' and Staff tea in the wards.
7.30 p.m.—8.30 p.m.	Nursing Staff supper in the wards.
7.45 p.m.	Christmas Show in the Physiology Theatre —Staff only.
Sunday, 26th December	
2.30—3.00 p.m.	Service in the Hospital Chapel.
Monday, 27th December (Boxing Day)	
2.00—4.00 p.m.	Visitors' Tea.
7.45 p.m.	Christmas Show in the Physiology Theatre, —Staff only.
Wednesday, 18th January	
6.45 p.m.—8.45 p.m.	Governors' Cocktail Party for the Sisters at the Clothworkers' Hall, Mincing Lane, E.C.3.

Crime and the Nurse

Keith Simpson, M.A., M.D., F.R.C.P., F.R.C.Path.

Nurses' names have seldom indeed appeared on any criminal Assize Calendar, and it would require but a slim volume to recount their contributions to the history of murder. Doctors, on the contrary, have a black record—Palmer and Pritchard, Neill Cream, Lamson, and Cross, Crippen, Ruxton, and the dapper Clements who dragged a young pathologist (who missed the morphine and committed suicide) down with him, are all historic. Dr. Bodkin Adams successfully defended a determined Crown prosecution on the same charge.

Charged with Murder

There have been two English names on the nurses' roll of dishonour, Waddingham and Southam, and of these, Nurse Waddingham was never on the State Register. Nurse Southam was certainly the victim of intolerable provocation by an elderly patient and lost her temper—no more. These two cases are worth a moment's reflection:

Dorothea Waddingham, a 36-year-old one-time ward orderly was convicted in 1936 of the murder in her nursing home of a 50-year-old Miss Ada Baguley by morphine. Miss Baguley had made a will in favour of "Nurse" Waddingham, leaving her £1,500 in return for life-long care in the nursing home for her mother (aged 89) and herself. A few days later the old lady died, and four months later Ada also died —very unexpectedly. A doctor, nevertheless, issued a certificate giving cerebral haemorrhage as the cause of death.

A remarkable letter purporting to be written by Ada to her doctor, sent after her death to the M.O.H. for Nottingham, because his signature was required for cremation, proved fatal. It expressed a wish for cremation and added:

"And it is my wish to remain with Nurse, and my last wish is my relatives shall not know of my death".

It was enough. Dr. Cyril Banks the M.O.H. ordered an autopsy and over three grains of morphine was found—a lethal dose. Exhumation of old Mrs. Baguley's remains, revealed the same cause of death. "Nurse" Waddingham was hanged.

Nurse Southam, a respected state-registered nurse, Matron of a nursing home at Worthing, was called in September, 1950, by a junior to help persuade a cantankerous old lady to swallow a night-cap. The old lady struggled to get out of bed, abusing the Matron and spitting the sleeping draught into her face. They had to tie the old lady's legs to get her into bed again and Matron was plainly so overwrought she lost her temper, held the old lady's head down on the bed, and pulled a pillow across her face to stifle her screams of "murder". The young nurse was present throughout and saw what the law would describe as an unlawful killing. It was an unfortunate end to a battle of personalities.

Matron did something unforgivable. She gave the nurse the pillow, straightened out the bed, called for the doctor and allowed him

mps

medical protection society est 1892

Unlimited legal aid
and indemnity against
professional hazards
throughout the world
(except U.S.A.)

Secretary Dr. H. A. Constable. Head Office
50 Hallam Street, London, W1N 6DE. Tel: 01-580 9241
or Regional Secretary Dr. P. G. T. Ford
Regional Office: 30 Park Square, Leeds 1. Tel: 0532 42115-6

to certify the old lady as dying of natural causes—something he had anticipated at sometime or another. The funeral was suddenly stopped when the nurse ran round to the doctors some 36 hours later and said what she had seen.

Mr. Justice Humphreys, doughty criminal judge as he was, plainly felt a lot of sympathy for the matron and invited the jury to regard the killing as manslaughter. Nurse Southam was sentenced to only three months—already absorbed by the period she had been awaiting trial at Lewes Assizes. She was released.

It would be idle to pretend that the doctor has more opportunity more access, more chance of covering up by certification. He certainly has the latter, and history shows he has used the privilege to cover his crimes. But the nurse has more private access, ample recourse to drugs, the bath or the pillow for the elderly. It is simply a fact that their record is better.

Crime in the Ward

Nursing is, on the whole, a profession of the dedicated, a quiet devotion to a duty that is often unpleasant and the pace of which is raised only by emergencies of surgery, crises in illness, and the occasional error in the use of drugs which demand quick counteraction. Most experienced nurses have never had anything criminal happen in their wards or nursing homes, their knowledge of crime and of forensic disciplines being limited to occasional ward occupants who have been victims of knifings or "beat-ups", or of suspects who have been admitted for treatment and are either wanted for questioning or have been charged and are awaiting an appearance at the Magistrate's Court—and are technically in custody.

But to assume that crime cannot happen in the quiet, well-run hospital ward is to live in an artificial atmosphere of deceptive calm. It can—and does.

In 1948 Peter Griffiths, an epileptic, broke into the Queen's Park Hospital, Blackburn, at night and took from a cot in ward CH3 a four-year-old child whom he raped and beat to death against a wall in the hospital grounds. An alert Sister, called by her staff, prevented the nurses from handling a Winchester bottle that stood by the cot (bearing fingerprints that convicted Griffiths) and from padding around on the floor wrecking the (socked) footprints that lay on the ward floor beside the cot. This was, indeed, an unusually alert sister.

Nurses can, on the contrary forget that they may be drawn into complicity with criminal acts:

In a case at Hertford a District Nurse had been called by a man to "lay out" the body of his wife who had "died suddenly" that morning. He gave her the key of the house, and she found the man's wife in bed with multiple stab wounds of the chest. What did she do?

She cleaned the body, removing the blood-soaked linen, boiling it in a copper and hanging the sheets in the sun, plugged the wounds with wool pledgets, laid out new bed linen—and leaving the house, placing the key where she had been asked to—telling no one of her

morning's professional work! Nurses are, indeed, taught to be tidy and to keep an orderliness about the ward and the sick room! She was only "laying" out the dead.

Not to be constantly on the *qui vive* (or should it be *qui meurt*?) is running the risk of overlooking altogether the act of murder, and a classical murder by poison took place in the Surrey County Sanatorium in Godalming, literally under the very noses of the nursing and medical staff in 1949.

Margery Radford, 42, had been under treatment for about a year for pulmonary tuberculosis. She was dying and this undoubtedly lulled the nursing staff—and the doctors—into a complacence or a lowered standard of suspicion when she complained of repeated bouts of sickness, that, to her, threw suspicion on her husband.

He, a St. Thomas' Hospital Laboratory assistant, with access to poisons of many kinds, was a lady's man, and she suspected him of a new liaison when he got his father-in-law to bring her lemonade in bottles he had diluted for her, and jam tarts he, her husband, had bought for her . . . little delicacies she fancied, as he knew very well.

When she died, thin, wasted, tuberculous, a doctor was more than prepared to issue a certificate to certify her death as due to chronic pulmonary tuberculosis. But several days before she died, she had asked a woman friend, Mrs. Formby, to take away a tart and some plums brought to her by her father as a delicacy from her husband—for she had been sick after eating them. Mrs. Formby took them for analysis, but was persuaded by her husband to return them to the Hospital Superintendent because it was a "complaint" about the food—"a matter for the Hospital", he said.

The Superintendent returned from a few days leave during which Mrs. Radford had died. The doctors were happy to give her a death certificate, and, knowing nothing of this, the Superintendent who found a parcel containing a tart on his desk (the letter accompanying this was in his secretary's office) ate a part of it with his tea that afternoon. Within a few minutes he felt "a certain amount of discomfort" in the stomach and was unable to face the evening's meal. Two hours later he was violently sick. He nearly died, for the tart contained $3\frac{1}{4}$ grains of sodium arsenite! It was next morning by the time he was handed Mrs. Formby's letter raising suspicion of poisoning, and the penny finally dropped. The police were called, autopsy confirmed arsenic poisoning. Radford was questioned, allowed home overnight—and found dead in bed, having taken prussic acid, the next morning.

Radford, on being told the facts (arsenic had been found in lethal amount in his wife's body) had put his hands to his head saying "I don't know anything about it. That means murder. I admit I bought the pies. Why should I want to kill my wife: I knew she was going to die anyway". It was precisely the reason why everyone was caught unawares. No one had considered the possibility that Mrs. Radford could be poisoned by arsenic under the very noses of the hospital doctors and nurses. It had never crossed anybody's mind.

A case of little importance—if of great significance in warning the staff that anything can happen in the ward—took place during the war years in a South London Hospital. A woman, visiting her dying husband—he had a cancer of the stomach, was allowed to sit with him in the ward behind screens that had been placed round his bed. Everything was quiet—as usual, and the ward staff, about their duties, had no idea that murder was being committed until a nurse, tip-toeing down the ward took a look over the screen to see that all was well. To her horror she saw that Mrs. X was up on the bed suffocating her husband with a pillow. She stumbled in, pulled the woman, by now crying bitterly, off the bed.

Unfortunately she reported the matter to the Ward Sister, who felt it her duty to report it to the Hospital Superintendent. The Police were called and the woman was taken into custody charged with the attempted murder of her husband. Two days later he died, and the charge was changed to "murder". Fortunately the young House Officer, when asked at the Lambeth Magistrates Court how he had found the old man the morning after the event said, quite innocently "If anything, Sir, rather better". The accused woman was discharged; the Coroner issued a certificate to say that the man had died as had, after all, been expected, of "carcinoma of the stomach".

Murder can undoubtedly happen in the ward. I have also had experience of a sex assault in a ward bed, of infanticide and of suicide as well as several attempted murders in the wards of general or of geriatric hospitals. No one can afford to be lulled into a feeling of "It can't happen here" for it can—and does.

A Nurse's Duty in Crime Investigation

All too frequently, victims of criminal assault are received into the Casualty Departments or admitted to the wards just as any other casualty is. It is forgotten that:

(a) Their clothing, with possible adherent hairs, fibres, dusts, bloodstains, etc. may afford vital clues, *and must be taken off with care*, sealed as separate items in paper bags, and labelled—not cut away and discarded, or bundled into one sack or bin to soil itself.

(b) Where there are stab or bullet or other wounds penetrating clothing, the holes and tears, the firearm pattern, the exact shape of the stab hole, the blood (sometimes from an assailant) provide important evidence. Photography is vital, and this *before* the surgeon cleans up things.

(c) Where fluid is running away from the mouth or some other orifice, it must be collected and labelled. All vomits and stomach wash-outs should likewise be preserved—and labelled.

(d) Where sex injury is suspected, early swabs may be vital—vaginal, rectal, maybe also oral.

(e) Where drink or drugs might conceivably or have more obviously played a part, an early (pre-transfusion) sample of blood must be labelled DO NOT DISCARD. Its group (before transfusion) may also be vital in laboratory matching with bloodstains on an instrument or an accused's clothing.

(f) The finger-nails should never be cleaned or pared down for the sake of cleanliness or committal to earth or cremation. Finger-nail scrapings have often afforded vital clues to an assailant. The body must not be cleaned and laid out as ordinary dead are.

(g) The earlier the police are told of an assault, a stabbing, a poisoning or any other offence, the better. The safety of other members of the public or of children may be at stake.

(h) The Press—who may ring the ward telephone or appear at the door—should always be held at bay with courtesy. The right person to give them information is the Officer in Charge of the case.

(i) Where statements are to be made, the police should be warned of the fitness of the patient to make a statement. Identity parades are better deferred until the patient is fit (vide the A6 case).

(j) Where crime is concerned, accurate note-keeping by the nursing staff is vital to any prospect of successful prosecution. Notes must be made "at the time" or as soon as is possible afterwards, and kept carefully filed.

Crime investigation is nowadays a trained scientific job in which both the casualty officer and the nursing staff of a hospital may take part. It requires a keen awareness of possibilities, and a wide awake alertness to the possibility of future crime enquiry.

Ward sisters and nurses commonly throw dirty things away—in order to keep the ward clean, but this is a dangerous habit. No ward sister should discard anything connected with the victim of crime until she has permission from the Police Officer in charge of the case to do so. On several occasions, dressings applied to injured persons or fragments of weapons removed at operation have proved fruitful in crime investigation, and specimens removed from the body during hospital treatment may provide useful analytical material. Such specimens as are needed for laboratory analysis should, if possible, be duplicated after careful labelling, and only one of these should be sent to the Hospital Laboratory. It has been said that such material should be divided into three—one for a laboratory check for treatment, the second in case the Coroner or Police or defence wish further analysis, *and a third for the nurse to throw away*! This may seem a little unkind, but the habit is so common that it is worth getting home to the nurse that notes, clothing, dressings, discharges, specimens, and laundry may all be vital. It is important for someone to be wideawake about this.

Only records made at the time, or materials carefully identified are admitted as evidence by Courts of Trial. No nurse or Doctor may "polish" his records in preparation for an appearance in the witness box, and it is better that the records should be too long rather than too short. The anaesthetist who used the word "alive" to describe the condition of his patient at the end of an operation was too brief, and the Police Surgeon in Cyprus who contented himself with a scribbled, almost indecipherable, two lines of report on a murder victim *scratched out on the letter of request sent to him*, was equally lacking in that sort of conscientious application which the Law expects of the medical profession as a whole.

Nurses and hospital doctors are expected to keep their eyes open, and though not to act as detectives, to see that clues to crimes are not overlooked, wrecked by treatment, or thrown away.

Reprinted from "The Criminologist," which is edited by Nigel Morland.

NURSING SECTION

ON BECOMING A STUDENT

At some time during one's career as a nurse, comes the inevitable task of making a decision about the future. This, as all nurses are well aware, is a somewhat limited choice. There are two directions, those of Administration, and teaching. However, should one undertake to become a tutor, it is possible after the formalities are over to find out what life is really like as a university student. After all when one was at school, the benefits of this life are constantly impressed upon the scholars. Additionally are these students really as slothful and antagonistic towards society as the popular press would have us believe?

Of course as a student undertaking the tutors' course one is regarded as a somewhat unusual species by the undergraduates, and they find it somewhat difficult to comprehend one's motives. This of course is understandable, if one thinks back to one's own views at eighteen years of age!

However, what adjustments does one have to make on becoming a student in this day and age, apart from the novelty of a half-day holiday every time there is a demonstration by the students about the latest misdemeanour of the government?

The first unusual phenomenon which is encountered is the fact that attendance at the college is not obligatory, provided that one is in evidence frequently enough to give the appearance of diligence. This is of course a very strange situation in which to find oneself. The inbred guilt of years is difficult to shed if one leaves when work is finished and not when the clock dictates. It takes time to cease worrying about who might want to know one's whereabouts and demanding an explanation. However, having conquered this not too mountainous hurdle, it is a very pleasant state of affairs.

Then of course there is the question of work. Again a new situation arises. Having always had to complete a specific amount before departing it is most strange to discover that provided the prescribed amount allocated for one term is complete by the end of that period, when it is actually presented is a matter on which each individual can decide. Thus one is at liberty for the first time to be very selfish and consider only oneself.

What then of the other students? Are universities the dens of iniquity that are described? The answer is definitely negative. These people appear to work extremely hard, and have less facilities very often than student nurses. The standard of food which undergraduates have presented to them is extremely poor. A quiet thought when one thinks of P.A.Y.E. looming ahead. The refectory in which they

have to sit can only be described as thoroughly sordid at meal times, with dirty crockery piled high on every table. The average nurses' dining room ranks as five star in comparison. Finally, nurses who complain about cloakroom facilities should view the alternative. Moreover soap appears to be a dirty word, since it is extremely difficult to acquire any.

One difference which one notices very soon is the lack of guidance regarding discipline. At the end of her training a nurse will at least have acquired this art. Not so one feels with the average undergraduate, and as a result they visibly lack the poise and confidence of the average newly qualified nurse.

The impression then, is that to experience this type of life at a later stage is at least if not more rewarding than it is as a teenager.

NOTICES

WEEKEND COURSE

"General Paediatrics and Paediatric Dermatology".

The British Postgraduate Medical Federation will hold a Weekend Course for General Practitioners and Local Authority Medical Officers entitled "General Paediatrics and Paediatric Dermatology". This will take place on Saturday, 26th February, and Sunday, 27th February, 1972 at the Evelina Hospital. Applications for a place on the course should be made to the Hospital Secretary, Evelina Children's Hospital, Southwark Bridge Road, London, S.E.1.

British Society for Social Responsibility in Science

Conference on "Social Factors in Health and Disease"

Friday, 7th January—Sunday, 9th January, 1972.
Old Theatre, London School of Economics.

The conference is arranged in five sessions with a total of 24 speakers.

Friday, 7th 7.30 p.m.—10 p.m. **Pregnancy and birth.**

Saturday, 8th 10 a.m.—1 p.m. **The community environment.**
2.30 p.m.—4 p.m. **The work environment.**
4.30 p.m.—6 p.m. **The impact of technology.**

Sunday, 9th 10.30 a.m.—12.30 p.m. Workshop sessions.
2.45 p.m.—6 p.m. **The politics of health.**

Speakers include: Prof. Sir Richard Doll, Prof. Maurice Backett, Prof. Neville Butler, Prof. Robert Case, Dr. G. Kazantzis, Dr. André McLean, Dr. Robert Ollendorss, Dr. Tudor Hart, Dr. Hugh Faulkner.

Further details available from: B.S.S.R.S., 70 Great Russell Street. Tel. 01-242 8535.

CORRESPONDENCE

Concepts of Death

SIR,—It came as a complete surprise to me to see my article on Death Attitudes in your last *Gazette*. It was "shelved" in 1967 because I had insisted on adding an introduction to the original paper, and the editors at that time, quite rightly, considered that it would then be too lengthy for publication in the *Gazette*. Perhaps you will allow me to add what must now necessarily become an Appendix.

When I wrote this paper in 1966 as a medical student, I had little experience of hospital practice other than at Guy's and had no experience as a practising doctor. Consequently, the paper tended to lack any emphasis on those points which were of practical importance, and in particular, the role of the relatives. In practice one of the most helpful points is the recognition that many patients with coronary artery or cerebrovascular disease experience the Presentiment of Death. Doctors, nurses and relatives tend not to recognise these people as "dying" and perhaps as a result of this are less tolerant of the patient's hostility, aggression and acting out. A short discussion with the patient, expressing the view that it is unlikely that they will "drop dead", but that generally there will be "a warning", which will bring help and comfort—can do a lot to dispel their fear.

It became clear to me as a houseman that doctors and, to some extent, nurses, cannot be physically available at all the times when a patient facing death openly, will need help. However, if this idea of round-the-clock commitment can be introduced to and encouraged in the relatives, many will welcome it, saying we would love to look after him at home, if only we could manage the nursing and his drugs. Since home care cannot always be arranged, perhaps we should be thinking in terms of "daughter-granny" units on the lines of the "mother-baby" variety. At least we could find out how many relatives would avail themselves of the facilities, if they existed.

Yours etc,

MARCUS PEMBREY

Picketts South,
Picketts Lane,
Redhill,
Surrey RH1 5RG.

The Rose Ball

SIR,—May I draw your readers' attention to the Clubs' Union Ball which is to be held on Friday, 14th January, 1972, at the Savoy Hotel.

Double tickets are at £6.50 and these will be limited to 200 to ensure adequate comfort for all concerned. Tables for any number up to 12 can be arranged.

Dancing will be to two bands to suit all tastes, and the dinner is guaranteed to live up to the Savoy's usual high standard.

Tickets may be obtained from Dr. C. J. Hunter-Craig (Department of Forensic Medicine), C. G. Langdon (East Wing) and from the Secretaries in the Medical School Office. Donations to the Tombola will be gratefully accepted and should be given to the Honorary Assistant Secretary.

Yours faithfully,

C. G. LANGDON,
Hon. Assistant Secretary.

Guy's Hospital Clubs' Union,
Medical School,
Guy's Hospital,
London Bridge, S.E.1.

The Ward Sister

SIR,—While having the greatest possible sympathy with the views expressed in his letter I feel I must register a protest about Dr. Joseph's use of the word "administrate."

Yours sincerely,

IAN MACKENZIE

Guy's Hospital,
London, S.E.1.

Phlebotomy

SIR,—Following the publication in the last edition of the *Gazette* of the results and comments on the questionnaire about phlebotomy we, as elected representatives in the field of Medical Education, would like to comment on them. The controversy about blood taking illustrates a general feeling of dissatisfaction amongst the student body about the way in which they are being utilised by the staff of the Hospital. In this country, we are fortunate in that we have considerable contact with the patients and to erode this would be a most retrogressive step. We help with the management of the patients and the clinical staff, in return, teach us. We regret that we are not more often informed and consulted about our patients.

We consider it desirable that we should take blood from our patients for a part of our medical course. However, we feel that on such firms as psychiatry and E.N.T., where students bleed patients about whom they know very little, this practice is of minimal value.

Investigations such as glucose tolerance tests, 51Cr E.D.T.A.'s and E.S.R's differ from most investigations in that students are often called away from rounds, lectures, or out-patients to take blood and record results and we consider that this should be done by technicians or house officers. The routine of blood taking could be simplified by ensuring that every ward has a complete phlebotomy trolley and that there is always an adequate supply of specimen bottles. We would also like the house officers to fill in the forms so that they think more about the investigations which they order.

Finally there is the persistent complaint that students are often asked to perform tasks which in other hospitals are performed by ancillary staff. Here it is up to the individual concerned to show his offence at being treated in such a manner. However we are often pressurised by the fact that if we do not accede the patient will suffer.

On Tuesday, 11th January, 1972, at 4.30 p.m. the Student Medical Education Committee will hold an open meeting in N. Common Room at which this subject will be discussed. All staff and students are welcome to attend.

Yours etc.,

Paul Hewish, Nick Bateman
Rhys Williams, Malcolm Levene,
Richard Darling, Jonathan Fox
Philippa Birch,

Student Medical Education Committee.

East Wing,
Guy's Hospital.

SPORT

CHANGES AT H.O.P.

Now that we are reaching the half-way point in the winter-sport season it is time to examine once again the conditions at H.O.P.

The luke-warm pies or sausage rolls are a welcome change from the sandwiches but a cauldron of beans to replace the red vinegar might make the snack more attractive.

The old system of credit has at last been stopped to the chagrin of many, but perhaps the bar will make a good profit this year.

The new heating system is a vast improvement and hot water lasts in the showers throughout the evening. However, there could be one or two more showers to help wash off the filthy "trough-water".

We still retain a singularly nonsensical locker system whereby all lockers are opened by the same key and there is only one key for 60 lockers. Also the present key disappears regularly, usually under a pile of rotting track-suits and this causes delay in changing. Missing a couple of games may mean that one's locker is emptied and the contents distributed in other lockers, or in the various cracks and crevices around the changing rooms. Why not have each locker with its own individual key kept by the owner, and the duplicate retained at H.O.P.?

However, the main problem is with the pitches at H.O.P. Stan Weller has now been groundsman for over a year and in one field there is great improvement—the 1st XV pitch which was saved from utter ruination by spending a large sum of money.

Nevertheless, the other pitches on close examination still reveal little grass which is far too weak. Of particular concern is the state of the soccer and hockey pitches which only four years ago were a joy to play on. Basically they need as much money and attention spent on them as on a grass tennis court, and should end up with the same standard of surface. A great deal more money must be spent on the football and hockey pitches so that they too can recover from their baldness. This money should be made available to the groundsman.

Grass, unlike hair, reacts to fertilizers and topsoil, but like hair can be pulled out if the roots are not deep enough. To get good grass we need the best seed and this should be the first priority for any improvement at H.O.P.

GUY'S WOMEN'S HOCKEY CLUB

GUY'S v. L.S.E.

Lost 1—0.

Nine players turned out for the first match that Guy's Women's Club has played for over a year. Lack of team practice was evident in the first half where Guy's were too slow and disorganised and let past a good goal. The second half was considerably better with all the players showing more determination and Guy's dominated play although no goals were scored.

Despite losing the first match there's every indication that more practice as a team will produce good results in our many fixtures next term.

Team: Janice Baker, Tessa Richards, Sue Overal, Ann Ouyang (Capt.), Eleanor Praed, Hilary Cole, Lynne Turner, Jane Deacon, Louise Broughton.

A.O.

THE WILLS LIBRARY
GUY'S HOSPITAL MEDICAL SCHOOL

HOCKEY

SPIROCHAETES v. OLD TAUNTONIANS

H.O.P. Nov. 7th 2.45.

Lost 1—4.

Old Tauntonians only managed, as usual, to field eight men, and Guy's generously donated one of our ace ex-Cambridge players. The teams therefore started ten to Spiros and nine to the opposition.

Spiros were fielding a somewhat scratch side, including the rugby playing Portelly brothers (by kind permission of the Mafia), two oarsmen Steve (I'm only here for the beer) Rigby and Dave Beardsley, plus assorted hockey players.

Despite this, Spiros started well, and looked dangerous especially down the left, where Cottingham, playing out of goal for the first time for a year, and Rigby linked up well. This threat seemed to evaporate when both players experienced breathing difficulties, due to too much alcohol, and not enough training.

Spiros gradually got on top of Old Tauntonians, and deserved the goal they scored. The ball came free to Mike Portelly on the edge of the D, and his bullet-like shot left their goalkeeper no chance.

Unfortunately Old Tauntonians struck back, with a goal which trickled between the goalkeeper's legs, but Spiros were not daunted by their lack of fortune, and continued to press strongly.

The first part of the second half saw Spiros, under the diplomatic captaincy of Nick Matthews, continually in the opposition's D, and they should have scored several times.

Once again lack of fortune and untypical goalkeeping by Nigel Bardsley allowed Tauntonians to hit back to finish 1—4 up at full time. This was a very enjoyable game, and the result gives little indication of the run of play.

Team: N. Bardsley, R. Fitton, J. Cottingham, R. Hannaford, N. Matthews (Capt.), M. Portelly, A. Portelly, S. Rigby, D. Beardsley, S. Weedon and Steve and Dave's flatmate.

J.C.

GUY'S v. BEXLEYHEATH

Lost 2—3

We were pleased to welcome Bob Forber back to the fold for this match, and indeed one of our main faults was our delay in utilising his skill, for it was not until late in the second half that he was able to show us that he had the beating of his opposing half-back.

Unfortunately we yet again conceded a goal within the first few minutes of the game, and not being content with that, this time we had a repeat performance a moment later. On both occasions our defence was drawn towards the ball too easily and we were beaten by the cross ball from the wing. If we stuck more rigidly to the principle of man-to-man marking this would not have happened.

Undoubtedly the man of the match was Paul Wilmer who has in the last three matches risen from the ranks of oblivion to a flourishing star, his crowning glory being two well deserved goals. The first was a rehearsed piece of opportunism in the shape of a neat deflection from a short corner,and the other a full-blooded welt from a ball pushed backwards across the D from the goal line by Roger Burns.

Once again we were pleased to have Richard Kendrick playing for us. Indeed he was the initiator of the "feed the Wilmer campaign" and after this performance even some of the more selfish members of the team have been convinced that our left wing is as effective as our right.

Although Bexleyheath played no better than us they were given the opportunity of making a result due to our backs being unwilling to get rid of the ball immediately whilst under pressure. They were robbed of possession and an easy goal resulted.

We failed to convert two short corners in the dying minutes of the game and so the score remained at 3—2 to Bexleyheath.

Team: K. J. Cottingham, B. Lakhani, P. Nicol, C. Crawshaw, T. Rubello, R. Kendrick, P. Wilmer, J. Walker, R. Clark, R. Burns (Capt.), R. Forber.

R.K.

RUGBY

GUY'S v. ROSSLYN PARK

Saturday, 20th November. Lost 37—13.

Rosslyn Park is a side which, like Guy's, has had fluctuating fortunes during the past few seasons. This year however, it has exceeded expectations by winning 10 out of 14 games, being second to London Welsh in the rating of London clubs and contributing more than half of its players to county sides.

There could have been little argument about which side was more favoured to win the game against Guy's. The hospital was still without its regular full-back, Danford, and Evans' continuing absence together with the unavailability of Rosewall deprived the front row of two props who had played so well together in the early games of the season.

A try and conversion within the first ten minutes allowed Rosslyn Park to push ahead in jaunty fashion. Their confidence at this time was ill-justified Although gaining a huge amount of possession their backs rarely moved with decision. The Guy's players contributed to the embarrassment of their opponents by allowing them limited space and seizing on what loose ball became available. A successful penalty kick by Novak brought the score to 6—3. There followed a series of vigorous assaults by Guy's and Owen was outstanding in these movements in that he collected awkward passes despite a buffeting and kicked with a fine tactical sense. Board, acting as a substitute full-back performed creditably and managed to link in attack on a few occasions.

For as long as Guy's were able to closely mark their opposition and tackle with effect they prevented the Rosslyn Park players from developing the planned moves of which they are well capable.

A superb effort by Barough brought a try for Guy's which Novak converted. The score at half-time was 12—9 to Rosslyn Park.

The pattern of play was unaltered immediately after the interval and Guy's were able to score yet again when Novak pushed his way forward, passed to Massey who gained ground before the ball moved to Druett then Barough and hence over the line. With the score at 12—13 Guy's were in an exellent position to win this game but for reasons not entirely explicable things began to go wrong.

For much of the afternoon Guy's had done well with limited possession but the Rosslyn Park domination of the set pieces and their ability to push the Guy's pack at will resulted in slow demoralisation. The Guy's forwards seemed less and less inclined to fight back, the back row lethargic in defence and the backs lost their concentration. A few vital tackles were missed and there followed a series of Rosslyn Park scores. Sadly the sequence was all too reminiscent of play the week before.

There is potential in the Guy's side this year. It will not be realised until the forwards work in unison and more determinedly at both set pieces and loose. Given this and a belief in the true capabilities of the side it should be a very good team.

Team: P. Board, R. Barough, A. Cambell, D. Stuart, R. Burlinson, S. Challacombe, M. Novak, R. Massey, B. Armstrong, T. Druett, T. Owen, T. Gibson R. Burt, N. Allen, R. Croft.

T.G.

GUY'S v. MOUNTAIN ASH

Saturday, 27th November, H.O.P. Lost 16—13.

A drab afternoon was not very much brightened by the initial play. Guy's seemed to exist in a torpor for most of the first half, shaking themselves into spasmodic activity which when they did indicated that they were clearly the better side.

The Mountain Ash players were not larger, faster, nor more skilful, yet by half-time they were leading 12—3, a goal and 2 penalties to a solitary penalty. Up to this point Guy's played poorly in every department except lines-out. Challacombe in particular jumped well and gained good possession.

With little of the first half remaining, the Guy's forwards encamped on the Mountain Ash line and won the ball from two successive scrums. From the first Croft predictably tried to fall over the line but his move was anticipated and blocked. From the second the ball moved out but a feinted scheme ended in confusion and Druett running in roughly the right direction but without the ball. The moment passed and the opportunity was lost.

The second half was livelier and two more penalties by the Guy's captain, Croft contributed to the score. Mountain Ash scored another try that was not converted bringing their total to 16 points. A vociferous band of Welsh supporters provided the supporting cast. As the light disappeared they chided the referee for not stopping the game prematurely and offered considerable gratuitous advice about how the laws should be interpreted.

At some time in the last 20 minutes the Guy's forwards moved into third gear and dominated the opposition from then on. Frustratingly, little happened. Croft completed his scoring spree after forcing himself over for a try. The backs ran a little faster with each move but it was all too late. Campbell on the wing received several good passes but his running lacked determination and given the opportunity to kick or pass he never failed to do so. On the other wing Armstrong may have touched the ball twice.

In summary the Guy's team performed disappointingly although several individuals attained a high standard of play albeit without consistency.

Team: P. Board, T. Druett, R. Barough, B. Armstrong, A. Campbell, T. Owen, R. Croft, A. Fallowfield, N. Allen, R. Massey, S. Challacombe, K. Rigg, C. Howell, D. Stuart, R. Burlinson.

T.G.

ARTISTS v. OLD WIMBLEDONEANS

Lost 42—3.

The late arrival of the referee caused the Artists premature exhaustion due to their enthusiastic "warm up"! This however, did not prevent them from giving a dazzling display of challenging rugby not entirely reflected by the score. The Artists played the first half up-hill, standing their ground well against the superior strength and weight of the Old Wimbledoneans pack. C. Langdon and J. Pearson attempted to crush the opposition physically, with little success ending in a half-time score of 24—0.

Undaunted, the Artists began a series of gallant counter-attacks, culmunating in a fine, first try by Paul Lewis some twenty minutes before time, from a down-hill dash (with a following wind).

Heartened by such spirit, the team withstood onslaughts of the most violent nature.

The Wimbledoneans' score reflects their fine co-ordination and speed but in no way detracts from the fine record of the Artists, unaccustomed to such professionalism.

Team: Rolands, Killik, Burr-Murdock, Simpson, Wheeler, Young, Pearson, Green, Langdon, O'Donnell, Townsend, Jones, Lewis, Grey, Kitchener.

P.W.

SOCCER

GUY'S v. THE LONDON

After an extremely frustrating 4—3 defeat by U.C.H. on the previous Wednesday, the first XI kept very quiet about their Saturday fixture and crept off to play the first round of the U.H. Cup against the team which defeated them 9—1 on an unforgettable afternoon in last year's final.

On a beautiful October day, the Guy's team lined up against all the old familiar faces in the London Cup side. The Guy's support was exactly average for a Cup match, Professor Haslewood turning up as always to shout lustily from the touchline. The opening five minutes saw Guy's on the attack and with Drage turning his back inside out on the left wing, Ramsey seized his chance to turn quickly on a centre and shoot through the hands of a surprised goalkeeper—a perfect start. London then started to remind us what a fast, powerful side they are, making several rapid breaks from defence and looking dangerous. During one of these attacks, a long through ball found two Guy's forwards unmarked and after a seemingly interminable time to the other ten members of the team, it was Drage who placed his shot safely in the net.

The pattern of the match from this moment until the end was one of incessant London attacks, broken only occasionally by rapid breaks by Guy's. Our forwards were not getting much change out of the centre of the London defence and London were getting most of the midfield possession by weight of numbers. However, the back line of four managed to plug all the gaps, although often leaving it uncomfortably late. Winter and Coley battled especially effectively in midfield, never allowing their opposite numbers enough time to be accurately creative. London scored a breakaway goal just before half-time, but the only score in the second half came a minute from the end when Baker caught the London defence square and raced through to squeeze the ball inside the far post. To borrow a saying, "Revenge is sweet".

Team: T. Walker, N. Harradine, A. Godman, D. Lindridge, J. Edwards, P. Coley, M. Winter, S. Drage, J. Ramsey, G. Barker, C. Baker.

N.W.T.H.

GUY'S 2nd XI v. MIDDLESEX 2nd XI

U.H. Cup Match: Saturday, 20th November, at Chislehurst.

Won 2—1.

Chislehurst was bleak and cold, but we were given a warm reception by a small group of Middlesex offspring, intent on making us the target of their acorn-throwing activities. Hence, it was obvious from the start that this match was going to possess the vital ingredients of a good Cup clash. Middlesex, having not lost either a Cup or League match this season, confidently arrived half-an-hour late, only in time to see a professional looking Guy's team in their new (1st XI cast-off) strip, ooze out on the field.

After 10 minutes, Guy's superior play bore fruit. Drew skilfully headed home across the box from Zukowski's pass, and five minutes later, with Middlesex still in a state of trauma, it was again Drew who quickly latched on to a bad back pass, and neatly slotted the ball under the Middlesex keeper, into the back of the net. This was still the score at half-time, but Drew was unlucky not to score his third hat-trick of the season, when he put in a brilliant driving header which unluckily hit a stupified Middlesex goalkeeper. Only once did the opposition come near to scoring, but Karani, foiled the attempt with a lightning clearance off the line.

The second half began in twilight and ended in total darkness, the only light being provided by a set of street lamps a few hundred yards away. Besides the darkness, Guy's were also handicapped in having to play up the slope against the wind and in a penalty area which was knee deep in deciduous foliage. Despite these setbacks, the strong, resolute Guy's defence held out—against the cheering of a Middlesex rugby team (antagonised by various well-known comments) and against a blatantly offside goal by the home team 15 minutes from time, when it was obviously even too dark to see the players.

K.G.B.

HOSPITAL INFORMATION

GUY'S HOSPITAL AND THE SOUTH EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited for the appointment of **Senior Registrar** in geriatrics to be made jointly by the Board of Governors of Guy's Hospital and the South East Metropolitan Regional Hospital Board with duties to commence as soon as possible and appointment until 30th September, 1975, subject to annual review. The successful candidate will work in the geriatric department of Guy's Hospital based at New Cross Hospital until 30th September, 1972. The following two years will be spent in the Brighton Group of Hospitals. Previous experience in general medicine or geriatrics and a higher qualification are desirable. Application forms are obtainable from and should be returned to the Superintendent, Guy's Hospital, London, SE1 9RT, not later than **29th December, 1971.**

SECRETARY required for Professor of Surgery. Age about 20-22. Good shorthand-typing essential. Apply giving details of age, education and experience to the Secretary, Guy's Hospital Medical School, London Bridge, SE1 9RT, quoting Ref. D.S.

PASS LIST

UNIVERSITY OF LONDON

Master of Surgery

November 1971

B. L. Whitaker

Third (M.B., B.S.) Examination for Medical Degrees

October 1971

Honours

G. M. A. Heaton (Distinction in Surgery)
Loretta Light (Distinction in Medicine)
A. M. Ross (Distinction in Medicine and Surgery)

Pass

A. I. Attwood
A. J. L. Brain
L. P. Harrison
B. Hartley
Gillian L. Hoare
D. M. Hunt
Sarah A. Lange
E. G. Latimer-Sayer
Vivien A. Leask
B. V. Martindale
B. J. Mason
F. O. Nwator
S. J. D. O'Keefe
G. L. Pryor
P. J. E. Smyth
Morna J. Van Essen
D. E. Ward

Part I

N. J. Astbury
N. K. Barber
A. J. G. Batch
D. N. Bateman
N. D. S. Bax
R. M. Darling
Rosalind M. Dismorr
G. C. Dunbar
Rosemary M. Ede
J. A. Fleetham
A. E. A. Ford-Jones
Dorothy M. Frost
Annabella M. Garnons-Williams
D. M. Gilman
R. A. G. Goodhart
A. H. Goudarzi-Langroudi
Lynne K. Hampson
I. D. Harrison
J. L. Hewlett
G. James
Lucinda L. Judd
T. Kidger
J. K. Klosok
Doreen A. W. F. Lee
J. L. Lewis
A. M. Light
Avril Little
Anne E. MacFarlane
H. U. S. McMichen
N. J. Marks
P. Matthews
M. L. Nancekievill
Dilys A. Neville
G. R. Pietroni
N. R. Pinder
A. J. Prisk
Sheila C. Rankin
D. R. Richardson
M. A. J. Rosenberg
C. J. Rudge
J. E. Scoble
M. M. Shaw
J. C. B. Shutes
P. J. Skinner
R. K. Stacey
I. D. St.B. Starke
M. A. Stodell
D. F. Stubbs
C. J. Thomas
S. G. Thompson
Hazel M. Tyson
Valerie J. Wass
R. W. M. Wright
N. O. Yerbury

Part II

C. J. Bennett
Margaret L. Cann
W. Edmonds
P. R. Evans
T. DeF. Mendis
A. J. Scourfield

Part III

Penelope Brain
W. Edmonds
P. R. Evans
P. Matthews
A. J. Scourfield

Part IV

Penelope Brain
Margaret L. Cann
P. R. Evans
P. Matthews
T. DeF. Mendis
A. J. Scourfield
A. J. Shellim
R. G. Thomson

ROYAL COLLEGE OF PATHOLOGISTS, LONDON

Primary Examination

October/November 1971

W. L. Brander
R. M. Ibbotson
Clare A. Topham
D. R. Turner

ROYAL COLLEGES OF PHYSICIANS OF THE UNITED KINGDOM

M.R.C.P.

V. Borirakchanyavat
C. B. Brown
J. C. Cutting
J. R. L. Froude
R. E. Pounder

SCHOOL OF NURSING, GUY'S HOSPITAL, S.E.1.

The following Nurses have passed the Final State Examination held in October, 1971:—

Ambrose, S.
Andrews, J. E.
Billson, C. C. (née Valli)
Bingham, S.
Birkin, S. A.
Bloomfield, J.
Boutell, S. J.
Brain, P. J.
Brown, P. A.
Cox, K. M. C.
Crofts, J. A.
Davies, C. E.
Davies, K. A
Denyer, S. M.
Dovey, M.
Downs, F.
Ducat, S.
du Plessis, D.
Edginton, J. S.
Ellins, J. L.
Farber, E. A (née Spedding)
Findley, M. E.
Freeman, D.
Grove, P.
Hamilton, M. A.
Hardy, S.
Hatton, J. A.
Jacks, J.
John, L.
Jones, R. M.
Kelly, M. R.
Kempston, B.
Kneale, S. J.
Ley, R. A.
McFarlane, R. J. (née Want)
Marks, E. M.
Martin, L. V.
Mead, J.
Mitchell, L. R.
Morris, H.
Norrish, J. D.
Nottage, H. M. (née Cole)
Orr, H. I.
Parke, C.

Pearce, A.
Phillips, A. H.
Pink, D. J.
Pitt, M. L.
Porter, J. E.
Price, G. M.
Prichard, S.
Richards, C. A.
Richards, J. A.
Setter, R.
Skinner, P. A.
Standley, J. S. (née Savill)
Tate, F. R.
Thompson, P. A.
Tooby, H.
Trimmer, R. G.
Twiney, S.
Vipas, C. D. (née Colby)
Walker, E. A.
Wallis, A. C.
Walter, C. L
Ward, E.
Waters, J.
Wilks, M. J.
Williams, S. J.
Beeden, J.
Bell, R. C.
Bellows, A. P.
Bulow, P. J.
Burns, N.
Egan, M.
Heggs, J. E.
Kneller, C.
MacManaway, J.
Payne, J. (née Young)
Pearce, V. R.
Whyte, M. A.

PERSONAL

ASSISTANT/ASSOCIATE dental surgeon required by Guy's man 10 minutes from the hospital. Five-day week. No Saturdays. Good remuneration. Tel: 237 2085.

CORNWALL—Opportunity for a fourth Practitioner to purchase into an expense-sharing association, all Guy's. Low seater equipment with own X-ray. Full staff. High professional standards are considered more important than high turnover. Potential for increased private work is good in this area. Good schools and excellent recreational facilities. Box No. 1/12.

FOR SALE—To fit man, 6 feet 2 inches: 1. As new, evening tail coat £8. 2. Morning dress coat and striped trousers £5. o.n.o. Tel: 01-504 7030.

FURNISHED FLAT—Eight minutes London Bridge. four rooms, bathroom etc. telephone, suit married couple, £12 p.w. Rev. R. J. Frost. Tel: 274 5001.

WE wish to extend to all our friends at Guy's our best wishes for a very Happy Christmas and a Prosperous New Year and sincerely trust that we shall have the greatest pleasure in renewing past acquaintances in 1972.

As ever,

Janet, Doris,
and of course Lassie.

"Thatchings",
Near Bognor Regis

CHANGES OF ADDRESS

Dr. Elizabeth Braithwaite, "Burnieside", 162, Woodland Drive, Hove, Sussex.

Mr. and Mrs. A. J. Pegg, 2 Romney Gardens, Sawbridgeworth, Herts.

Dr. and Mrs. John Powell-Jackson, 4, Connell Crescent, Milneavie, Glasgow.

Dr. and Mrs. W. G. Reeves, "Arden", Hedgerley Village, Gerrards Cross, Bucks. Tel: Farnham Common (369) 2236.

Miss S. A. Sopwith, St. John's Nursing Home, "Bramley Croft", 129, Haling Park Road, South Croydon, Surrey, CR2 6NN. Tel: 01-688 3053.

George and Christine Taft, S.R.N., S.C.M., 1400 S. Joyce St., Apt A-502, Arlington, Virginia, 22202, U.S.A.

Mrs. S. H. Wass, 8, Grenville Court, Lymer Avenue, London, SE19 1LR. Tel: 01-670 2061.

Dr. and Mrs. Stan Williams, 32 Hill Drive, Hove, Sussex, BN3 6QL.

BIRTHS

RICE—To Charles and Mary (née Restell), on 16th November, 1971, a son John Charles, brother for Elizabeth.

TONG—On 26th November, 1971 to Beryl (née Gibsen) and David Tong, a daughter, Alison Louise, sister for Suzanne and Richard.

BOOKS

Killey, H. C., Kay, L. W. and another. *An outline of oral surgery. Part* 2. John Wright, Bristol, 1971.

Wadsworth, M. E. J., Butterfield, W. J. H. and Blaney, R. *Health and sickness: the choice of treatment.* Tavistock Publications, London, 1971.

PAPERS BY GUY'S MEN

Black, P. J. Epitaph for the M.C.H.C. *British Medical Journal,* 1971, **4**, 492. (Correspondence)

Dornhorst, A. and Ouyang, A. Effect of alcohol on glucose tolerance. *Lancet*, 1971, **2**, 957.

Gosling, R. G., Newman, D. L., Bowden, N. L. R. and Twinn, K. W. The area ratio of normal aortic junctions. *British Journal of Radiology*, 1971, **44**, 850.

Parsons, V., Davies, C., Goode, C., Ogg, C. and another. Aluminium in bone from patients with renal failure. *British Medical Journal*, 1971, **4**, 273.

Robinson, R. The small-for-dates baby—II. *British Medical Journal*, 1971, **4**, 480.

Smithen, C. S., Balcon, R. and Sowton, E. Use of bundle of His potentials to assess changes in atrio-ventricular conduction produced by a series of beta-adrenergic blocking agents. *British Heart Journal*, 1971, **33**, 955.

Smithen, C. S. and Sowton, E. His bundle electrograms. *British Heart Journal*, 1971, **33**, 633.

PRIVATE GUY

AN UNDERGROUND JOURNAL

EDITORIAL

Christmas greetings to all our shareholders together with my mother and Mrs. Gladys Mould of Penge West. This has been a good year for us all, particularly for Mrs. Gladys Mould of Penge West, who recently lost her left kidney during a dog-fight over Brockley Rise. This was returned to her through the kindness and generosity of our retired matron's Guild together with the help of Mr. Edward Mould (64) of Penge East.

Nobody knows better than I, how much we owe to these noble women and Mr. Edward Mould (94 retired), who gave their all and received only our gratitude and a £4 organ token, exchangeable at W. H. Guy's and Organ Co. Ltd., in the Penge district of South London.

This year many organs have been exchanged, a trend which we hope will continue. Unfortunately, the rising bank rate has forced us to go public, although we shall continue to remain private in parts.

We look forward to another productive year, and in closing my Christmas message may I remind you that all last year's tokens must be returned to our South Penge Bank by Sunday, 26th December, when the winning number will be drawn by Mrs. Gladys Mould (63) recently deceased but resuscitated through the goodwill of Mr. Edward Mould a local (cont. P. 79).

NEWS

PENGE BY-PASS PROBE

From our changing room correspondent Cissy Lung.

Before the big match yesterday afternoon, between the Penge By-Pass eleven (A.229) and Brawn's Brockley Bunglers, which took place before a large crowd of sleeping technicians, the atmosphere was electric and distinctly sweaty. Referee, Herr Adolf Schultzonger said he was overpowered and drunk. "I am overpowered" he said as I helped him blow his whistle. He was clearly drunk.

The first half finished at half-time, when bananas were brought on by Staff Commandant Air Vice-Marshal Sphutt (12½) who said "From my point of view personally I don't know why the world stands by and lets this sort of thing happen to innocent people".

Latest score: Brawn's Bunglers 29 all out.

Penge By-Pass 11.

In the second half tempers were lost. Schultzonger took many names and telephone numbers; after 16 free kicks Brawn retired hurt and the match was abandoned due to poor visibility.

Penge By-Pass eleven were relegated to the B.2138, and walked out in protest.

(Overshoes should be returned to Cissy Lung and Co. Ltd., Penge Theatres, P.O. Box 139721.)

A DOMESTIC TURKISH OR VAPOUR BATH

By means of this simple apparatus any person can enjoy a Turkish or Vapour Bath in his own bedroom for one penny. Requires no fuel or gas, apparatus or pipes, nor fixing in any way. Entirely free from dirt or noxious vapours. Can be used for children.

Price of Bath and Lamp £1.15; with waterproof or Flannel Cloak, complete, £2,000.

MANUFACTURED AND SOLD BY

EDWARD MOULD

"Chez Mould"

PENGE WEST.

IT'S WAR

War broke out last night between East and West Penge. These hostilities follow demands by East Penge for recognition as an independent suburb under the leadership of Major-General Edward Mould (Vict. 2nd Class) who polled 97 per cent of the votes in the recent by-election. The border between East and West Penge has been closed and an air-lift is now under way to remove the 17 foreign grocers, delicatessen owners, and restauranteurs, to the safety of Highgate Village and Golders Green.

Reports coming in from the front indicate that there is heavy traffic on the by-pass with occasional sorties on to the B2138. The first casualty seen at Penge Cottage Hospital by Dr. Abdul Singh (24—locum consultant in orthopaedics, G.U., gynaecology and dermatology) has been referred to a large South London teaching hospital for a second opinion. Dr. Singh's only comment was, "I'm afraid I'm not sufficiently qualified to comment".

Needless to say, the stories of torture, atrocities and rape are filtering through; although it is being said that members of the Tory Women's Association offered little resistance. Detainees being held

in the little known Southern Region Station of Penge West are being subjected to the cruellest "ill-treatment" in the waiting room. Some are being forced to stand with their hands in their pockets, their heads covered by brown paper caps, whilst in the background the drone of Mrs. Gladys Mould is being used to disorientate them in place and time. Indeed the number of times I have been asked today, "Got the time, mate?" makes me wonder whether the rumours are not without foundation.

Of course the big question being asked by the man in the street, apart from the time, is, "which side will the major powers support?" The United Dairies have a great deal of money, as well as 763 unreturned milk bottles, invested in East Penge. Surely they will not stand idly by? The recent move by Chinacraft to larger premises in West Penge now takes on a far more sinister significance. And it is not yet known with whom the sympathies of H.P. Sauce and Co. lie. No doubt, over the next few days, all these questions will be answered. Let us only hope that the tragedy of divided East and West Croydon does not befall the peace-loving community of Penge.

And so from the battle-torn A229, we move to the sensual . . .

(cont. p. 77)

SENSATIONAL RUMOUR CONFIRMED

Guy's Hospital Reports (Nos. 3 and 4)
For 1971 will be Published in 1972 or 1973

PRINTERS QUIVERING IN ANTICIPATION

SHOCK RUGBY RESULT

PROBE DEMANDED

St. Tumour's Hospital - 3 Father Xmas Old Deer's XV - 0

Said red-eyed Tom "The Doc" ffitch William (M.D.), sometime athlete, university professor and now manager of the ever-entertaining South Bank Hospital side: "I don't know what went wrong with the boys. They must have had a brainstorm. Why, if they carry on like this we'll lose our public following and national press coverage."

Attractive slim-hipped Doc. ffitch is a chartered accountant.

UNCLE NIGEL'S

CHRISTMAS QUIZ

Pair the quotation with the appropriate speaker

1. "There are three things in my life that I will never forget; the Kruger National Park, the Great Barrier Reef and I can't remember the third thing."
2. "Never seen it."
3. "Silly me."
4. "Things will be different in October."
5. "Don't just stand there, cut it off."
6. "He reminds me of an absent-minded professor, but I can't think what his name is."
7. "Good."
8. "There hasn't been a Tory government since the war."
9. "Now is the time to maximalise outpatients potential and discharge you at the end of the week."
10. "It falls on my head if they do."

Dr. Stafford-Clark
Dr. Joiner
Prof. Sir Hedley-Atkins
Dr. Mann
Prof. Warwick
Dr. Hardwick
The Editor
Mr. Blackburn
Mr. Rendall
Mr. Lawrie

MULTIPLE CHOICE

HOW GOOD A DOCTOR ARE YOU?

1. An epidiascope is :
    1. Useful for visualising the epididymis?
    2. Used for looking into the Nurses' Home.
    3. No longer used.
    4. Part of Prof. McColl's collection.
    5. All of the above.
2. What would inspire you to make use of the casualty lavatory?
    1. Monday morning O.P.O.
    2. A full bladder.
    3. Mr. Crabbe.
    4. Orthopaedic Take-in.
    5. None of the above.

3. A sigmoidoscope:
    1. Can visualise the kidney.
    2. Is good for oiling big-ends.
    3. Is tuned to middle-C.
    4. Is a Greek weapon.
    5. Was used in the Battle of Trafalgar.
4. A consultant stands on your foot. Do you
    1. Wait patiently until the end of the round?
    2. Apologise for standing under his feet?
    3. Punch him?
    4. Call in Orthopaedic Take-in?
    5. All of the above, quietly?
5. A patient faints during phlebotomy. Do you
    1. Faint?
    2. Finish taking the sample?
    3. Write up an E.E.G. request?
    4. Set up a CVP line?
    5. Contact Lynne Hampson, student president?

OBITER DICTA

T★N★ R★C★A★D★ (percussing an abdomen):
"Resonant, resonant, dull, dull."
Patient: "You're —— dull an' all."

Student: "Do you have any trouble with your back-passage?"
Patient: "Yes. My husband leaves his motor-bike in it all day."

Student to coronary patient in Casualty:
"Has anyone else in your family died recently?"

Consultant to shapely female student who is examining a patient:
"What can you feel, my dear?"
"Your hand on my bottom, Sir."

PROFESSOR B★TT★RF★★LD:
"Has anyone been along with a machine to count your legs recently?"

Tense Time Defined—A Riddle

Future perfect in the past,
How long do you think it all will last,
The present's historical all too fast.
The future's tensed and imperfectly is passed.

MICHAEL POLLOCK

GIFTS

1. Gift: The thing given (M.E.)

2. Gift: A faculty, power or quality, miraculously bestowed (M.E.)

3. Gift: Poison (German).

"Gift ist kein geschänk . . ."

Nanny Goethe: Sayings to my son.

Johann Wolfgang Goethe was fed up to the teeth with his Christmas presents.

"What did you expect?" his wife Christiane enquired.

"To be master of the genre, duckie, not a bloody pair of socks. Socks as a gift leave me as uninspired as East Wing Soup. (In Goethe country, in the month of Christmas, soup is made entirely from East Wings). After many weeks cleaving leprous feet from bilgy boots, those socks (thank you Nanny and Billy, they're really great) are gift all right," He said, changing languages instead of you know what.

"The whole family was watching my excited little fingers scratching away at the pretty paper wrapping, only to reveal this masterpiece of selection, conceived with me in mind. Oh Jawohl, socks for Johann, what would that imbecile want with books or a new biro? And so my dear, my eyes simply refused to shine with delight. I am no longer able to reclaim the sense of pleasure of a five-year-old receiving his first pair of underpants."

"Face it old man, the folks know that you are a sock fetishist."

Meanwhile, not a hundred miles from Birmingham, there is an immunologist who doesn't wear socks. It is remarkable what lengths some people will go to in order to declare what they want for Christmas . . . He is getting "The Case of the Megaloblastic Racehorse", Mahler's Ninth Symphony by Kubelik, Mud Slide Slim and the Blue Horizon, an anatomical snuff-box, one ml of fluorescinated IgE antiserum, sticky shoes, an electric dustbin and a device for making creamy porridge at the zoo. Ay, there's the rub. Whatever will they think of next, Doris? Socks will sooner or later go the way of most feet. That is more than we can say for some of the more remarkable contrivances distributed for the festive season. The International Federation of Zoological Gardens (TIFZOG) have fully approved this exciting gift and that of course makes all the difference.

I know exactly what I want: I want something else. Anyway, to throw in a cliché, the real gifts don't come in packets: To play the 'cello like Mrs. Barenboim or like my mate Mel, seeing swans take off, to look like Marty Feldman, or to inherit the self-assurance of a Guy's man in a Hong Kong Mezuzah factory (that really should come in a packet). The socks are for people without shoes, the porridge for

people without bread, the books for people without liberty. Such gifts may be received without gratitude because survival is the beginning of all needs. Survival alone is too much. Unsatisfied needs may make anguish; unneeded satisfaction may make poison. The definition of authentic needs may be partly assisted by Nanny Goethe's response, when she was given a motor-boat by her son:

"Poison is not a present. If I need nothing more than a motor-boat, then I need nothing."

She continued to give him socks each year. He cursed but he wore them until they carried him to his destiny.

A.N.F.

DEAR PRIVATE GUY

DEAR PRIVATE GUY,

My husband is due back from 18 months continuous service in Malaysia. I am 8 months pregnant. What should I do?

Signed,

DISTRESSED.

Dear Distressed,

Blame it on the Pill.

* * *

DEAR PRIVATE GUY,

I am 15 but can easily pass for 19. For two years I have been going steady with Dennis. Dennis is a handsome, mature 63-year-old actor whose talents are vastly under-rated. My parents were constantly interfering with us and our love, so now I have left home to go live with Dennis.

Signed,

PRECOCIOUS.

Dear Pre,

You should go home. Dennis will not live long anyway.

* * *

DEAR PRIVATE GUY,

For the last two years now, I have done nothing but go to wild orgies, ravy parties and dates. On each occasion I end up in bed with a beautiful girl. However, I am now a broken man of 21 and sex has become more of a reflex action than a source of entertainment and enjoyment. What can I do? Can you help me?

Signed,

BORED.

Dear Bored,

My private telephone number is 794 7171.

SILK UNDERCLOTHING

PURE SCOTCH WOOL UNDERCLOTHING

Especially adapted for cases of Rheumatism

KNEE CAPS and SLEEPING SOCKS

EDWARD MOULD

and Daughters Strictly Limited.

MOULD HILL

PENGE WEST

A DAY AT THE OFFICE

Doctor: Come in, sit down.
Man: Thanks, Doc.
Doctor: What is your name?
Man: Fred Claxton.
Doctor: Is that spelled with a "K"?
Man: No, with an "F" Fred . . .
Doctor: I see. Well, what's the matter?
Man: No idea!
Doctor: Can you tell me what has been troubling you?
Man: I got this pain, like.
Doctor: Where is this "pain"?
Man: Don't know really.
Doctor: Well, is it in the top half of your body or the bottom half?
Man: Depends where you draw the line donnit? (*Points around his body.*) It sort of starts here, spreads up here and down here, and sometimes I feel it here, here, and here.
Doctor: What sort of pain is it?
Man: 'orrible!
Doctor: No. I mean, what does it feel like?
Man: Hard to say really . . .
Doctor: Is it, say, a burning pain?
Man: Oh, don't know . . .
Doctor: Sort of like this? (*He burns the man with his cigarette.*)
Man: Ahhhhhh! No, nothing like it. My God!

Doctor: Hmm, is it a stabbing pain?

Man: Don't know, do I.

Doctor: Well, is it like this? (*Stabs the man with a knife.*)

Man: Ahhhh! No, not like that. Bloody hell!

Doctor: In that case, is it a gripping pain?

Man: Can't say . . .

Doctor: Well, is it like this? (*Strangles him.*)

Man: AhhAhhhh . . . (*Expires.*)

Doctor: I do wish these people would learn how to express themselves. Next please.

LETTERS*

SIR,—On behalf of Arnold and myself I would like to take this opportunity to wish all our readers a Merry Christmas and a Happy New Year. As Uncle Yuri used to say, as he fed the pomegranates;

"A bird in the hand spoils the broth,
But many hands shouldn't throw stones."

Yours sincerely,

CONSTANCE SCHULTZBERGER, M.S.

SIR,—I beg humbly to use your venerable columns once again to express opinions which leftist editors do not usually print. I wish to point out that students have had an easy time to date and they do not deserve unions. The Government gives them money so they can study for examinations and it is not to be used for such frivolous activities as eating, drinking and playing rugby football within a union. I am surprised that students have reacted so badly to what is a reasonable and liberal proposal by the Government. I am surprised at the Government for not taking more radical action to stamp out leftist student politics. As long as long-haired socialists run student unions, I shall not sleep in peace.

I would be surprised if an underground leftist journal such as yours, Sir, would publish this letter.

I beg to remain your humble and obedient servant.

Yours truly,

E. D. BEAMISH, M.C.B.

"The Armoury"
Isle of Wright.

*All correspondence should be addressed to the Editor, *Private Guy*, Parkhurst Prison.

PRIVATE GUY PUZZLES

A CLEVER STUDENT

Of Charles, Tom and Bill.

Charles says truthfully:

1. If I am not clever, I will not pass Therapeutics.
2. If I am clever, I will pass Pathology.

Tom says truthfully:

3. If I am not clever, I will not pass Pathology.
4. If I am clever, I will pass Therapeutics.

Bill says truthfully:

5. If I am not clever, I will not pass Therapeutics.
6. If I am clever, I will pass Therapeutics.

While:

A The clever man is the only man to pass one particular subject.

B The clever man is the only man to fail the other particular subject.

Which of the three men is clever?

HOW WIDE IS THE RIVER?

Two ferry boats start moving at the same instant from opposite sides of the Thames, one boat is faster than the other, so they meet at a point 720 yards from the nearest shore.

After arriving at their destination, each boat remains fifteen minutes alongside to change passengers, then it starts on its return trip. The boats meet again at a point 400 yards from the other shore. What is the exact width of the river at this point?

WHAT HAPPENS TO THE WEIGHT?

If to a rope, passed over a frictionless pulley, is suspended a ten-pound weight that exactly balances a monkey at the other end, what happens to the weight if the monkey attempts to climb the rope?

(Assume both rope and wheel are weightless and frictionless).

If you get a little stuck refer to the letter by A. G. Samuelson in Scientific America, June 1956, page 18.

The answers will be published in the next issue.